FOREWORD

CHAPTER 1 - GENERAL ADP REQUIREMENTS

CHAPTER 2 - TRICARE ENCOUNTER DATA (TED)

DRAFT

NOTE: Changes from the ADP Manual up to Change 19, TRICARE Prime Remote for ADFM, and TRICARE For Life have been incorporated.

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TRICARE
MANAGEMENT ACTIVITY

FIDA

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FOREWORD

The TRICARE Systems Manual (TSM) 7950.1-M defines the contractor's responsibilities for automated processing of health care information, reporting and transmission of relevant data between the contractor and the TRICARE Management Activity. The manual also provides the requirements for the Managed Care Support Contractors (MCSCs) to interface with the Defense Enrollment Eligibility Reporting System (DEERS) for performing TRICARE Prime enrollments onto DEERS and obtaining beneficiary eligibility verifications from DEERS.

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CHAPTER 1

GENERAL ADP REQUIREMENTS

SECTION SUBJECT

CHAPTER 1
SECTION 1.1

GENERAL ADP REQUIREMENTS

1.0. GENERAL

1.1. The TRICARE Systems Manual defines the contractor's responsibilities related to automated processing of health care information and transmission of relevant data between the contractor and TMA. It covers three major categories of information flowing among the contractor and TMA and DEERS: health care service information, provider information and pricing information. For each of these categories it presents specifics of submission, record and data element specifications, editing requirements, and TMA reporting of detected errors to the contractor.

1.2. This chapter addresses major functional and technical requirements related to the flow of health care related ADP information between the contractor and TMA. TRICARE Encounter Data (TED) records as well as provider and pricing information must be submitted to TMA in electronic media. This information is essential to both the accounting and statistical needs of TMA in management of the TRICARE program and in required reports to Department of Defense, Congress, other governmental entities, and to the public. Technical requirements for the transmission of data between the contractor and TMA are presented in Chapter 2, Section 1.1. The requirements for submission of TRICARE Encounter Data records and resubmission of records are outlined in Chapter 2, Section 1.2, the TMA requirements related to submission and updating of provider information is outlined in Chapter 2, Section 1.3 and the TMA requirements related to submission and updating of pricing information is outlined in Chapter 2, Section 1.4.

1.3. The ADP requirements will incorporate the HIPAA mandated standards wherever feasible. These standards are being reviewed and will be incorporated in a future version.

2.0. ADP REQUIREMENTS

It is the responsibility of the contractor to employ adequate hardware, software, personnel, procedures, controls, contingency plans and documentation to satisfy TMA data processing and reporting requirements. Items requiring special attention are listed below.

2.1. Backup System

2.1.1. Reliable backup for hardware, software, data files and personnel must be available to ensure continuous data processing when any of the listed primary components are not available for an extended period of time. These requirements can be satisfied by ensuring access to alternate hardware, regular backup procedures for application software and data files, and a backup plan for acquiring personnel in an emergency situation. All these measures must provide for timely recovery of data processing services following an interruption.

2.1.2. The contractor will conduct a test of the backup system within the first quarter of the initial health care delivery period and will continue to assure backup capabilities by testing or reviewing the availability and capability of the backup ADP system to process the TRICARE data and produce the expected results. Review of the primary ADP system configuration with the backup ADP system must be done at least semiannually. The contractor's testing of the backup system will be done at least once a year.

2.1.3. The test in the first quarter and the annual test must include a representative sampling of at least four hundred (400) of the various health care records routinely processed by the contractor. If the test does not produce results which are equal to those achieved on the contractor's primary system, the contractor shall take immediate steps, and within ninety (90) days reestablish a backup ADP system acceptable to TMA. In all cases, the results of the review and/or test results will be reported to Contract Management Directorate, TMA, within fifteen (15) days of conclusion of the review or test.

2.2. Security

2.2.1. The contractor has the responsibility to ensure that TRICARE program records in its custody, whether in machine readable form or hardcopy, are protected from unlawful disclosure, fraud or embezzlement. The Privacy Act of 1974 requirements must be applied to production test and distribution of hardcopy reports, to labeling and mailing of magnetic tapes, to restrictions of online access to data files, and to destruction of reports and magnetic tapes. These records must be protected from malicious or inadvertent destruction, and also from loss due to natural disasters.

2.2.2. OPM Part One, Chapter 1, Section V. outlines specific statutory requirements for control and/or release of information. The contractor, in processing TRICARE data, develops and maintains information files which fall within requirements of these laws. Control of access, either physically or electronically, to the contractor's TRICARE program software, operational data files, documentation libraries and off-site storage areas must be limited to those persons with a legitimate need to access and use the information. All factors discussed above must form a basis for the contractor's security plan.

2.2.3. All systems processing sensitive but unclassified information or information subject to the Privacy Act of 1974 shall be protected. All contractors supporting TRICARE healthcare delivery programs (e.g., TRICARE Senior Prime) will comply with the security requirements process as defined by DoD 5200.40 (DoD Information Technology Security Certification and Accreditation Process (DITSCAP)), and as stated in this Manual.

2.2.4. Specific Security Requirements:

2.2.4.1. The contractor shall comply with DoD Minimum Security Requirements, DoD 5200.40 (DITSCAP), Health Insurance Portability and Accountability Act (HIPAA) (specifically the Administrative Simplification section of the Law, including the security, electronic signature, and privacy standards), Privacy Act Program Requirements (DoD 5400.11), Personnel Security Program (DoD 5200.2-R) and the MHS Information Assurance Policy Manual.

2.2.4.2. All contractor or contract leased or supported IT systems that process, sort, transmit, or access sensitive but unclassified government information or information systems

will obtain security certification and accreditation IAW DoD 5200.40 (DITSCAP) and the supporting guideline documents published by the Defense Information System Agency (DISA).

2.2.4.3. The MHS Information Assurance Team will provide guidance in the development of security documentation specified by the security references above in support of the certification and accreditation process.

2.2.4.4. Documentation includes an overall System Security Authorization Agreement (SSAA), a Vulnerability Assessment, Risk Analysis, Trusted Facilities Manual, Security Features User's Guide, and other security documents as defined within the referenced directives and standards.

2.2.4.4.1. Explanation of the System Security Authorization Agreement: The SSAA is a living document that represents the formal agreement among the Designated Approving Authority (DAA), Certifying Authority (CA), User Representative, and Program Manager. The SSAA is used throughout the entire DITSCAP to guide actions, document decisions, specify Information Technology Security (ITSEC) requirements, document certification tailoring and level of effort, identify potential solutions, and maintain operational systems security. The primary objectives of the SSAA are provided below:

- Document the formal agreement among the DAA(s), the CA, the user representative, and the program manager.

- Document all requirements necessary for accreditation.

- Document all security criteria for use throughout the IT system life cycle.

- Minimize documentation requirements by consolidating applicable information into the SSAA (security policy, concept of operations (CONOPS), plans, architecture description, etc.).

- Document the DITSCAP plan.

The SSAA is updated in each phase as the system development progresses and new information becomes available. The SSAA consolidates the system and security documentation into one document. This eliminates redundancy and potential confusion as multiple documents describe the system, security policy, system and security architecture. When feasible, the SSAA can be tailored to incorporate other documents as appendices or by reference to the pertinent document

2.2.4.4.2. System Security Authorization Agreement Appendices:

2.2.4.4.3. System Design Document: Describes the framework for the information system security architecture that includes a physical description of the hardware, software, firmware, interfaces, and Data flow.

- Hardware: Describes the hardware used and whether it is a standard commercial product, unique, or on the National Security Agency (NSA) Evaluated Products List (EPL). Include an equipment list and describe the target hardware and its function.

- Software: Describes the operating system(s), database management system(s), and applications. Documentation software includes the entire set of application programs, software procedures, software routines, and operating system software associated with the system. This includes manufacturer-supplied software, other commercial off-the-shelf software, and all programs generated applications software. The features of any security packages used on the system should be identified and described. Identify any software packages that are commercial off-the-shelf (COTS), government off-the-shelf (GOTS), and on the EPL and describe the target software and its intended use.

- Firmware: Describes the firmware used and whether it is a standard commercial product, unique, or on the EPL. For example, items such as Programmable Read-Only Memory (PROM) and erasable PROM (EPROM) devices are considered firmware. The software that is stored permanently in a hardware device that allows reading and executing the software, but not writing or modifying should be described.

- System interfaces and external connections: Describes the significant features of the communications layout. A high level diagram of the communications links and encryption techniques connecting the components of the information system, associated data communications, and networks should be included. Describe the system's external interfaces. The description should include a statement of the purpose of each external interface and the relationship between the interface and the system. Provide information on all Ports and Protocols used.

- Data flow: Describes the system's internal interfaces and data flows. The types of data and the general methods for data transmission should be stated. Diagrams or text to explain the flow of critical information from one component to another should be included.

2.2.4.4.3.1. System Rules of Behavior: This appendix provides an established set of rules of behavior concerning use of, security in, and the acceptable level of risk for, the system. The rules shall be based on the needs of the various users of the system. The security required by the rules shall be only as stringent as necessary to provide adequate security for information in the system. Such rules shall clearly delineate responsibilities and expected behavior of all individuals with access to the system. They shall include appropriate limits on interconnections to other systems and shall define service provision and restoration priorities. Finally, they shall be clear about the consequences of behavior not consistent with the rules.

2.2.4.4.3.2. Contingency Plan(s): Describes the rapid recovery of a system in the event of an outage or interruption to automated mission operations. This document should describe the emergency responses, backup procedures, backup operations, and recovery. An outage or interruption may be caused by damage to facilities, equipment, software, or data that comprise the system or application. The plan provides an organized method for restoring automated mission operations to a useable level that will support crucial mission functions during times of emergency or until full and permanent operations can be restored. The plan defines the responsibilities of each person expected to play a role during the emergency and requirements for testing the plan. The detail of the contingency plan is influenced by the IT environment, the criticality of the functional applications being supported, and the user's requirements.

2.2.4.4.3.3. Security Awareness and Training Plan: Describes the security-training plan based on the written rules of the system. The type of training and the content should be specific to what each type of user needs to know to use the system securely. Documentation should include how specific groups of users will be trained and what that training will include. Subjects to be covered should include work at home, dial-in access, connection to the Internet, use of copyrighted works, unofficial use of government equipment, the assignment and limitation of system privileges, individual accountability, technical security controls (e.g., password use), proper use of applications, how to get help, and restoration of service as a concern of all users of the system or application.

2.2.4.4.3.4. Incident Response Plan: Describes policies and procedure for providing a capability to help users when a security incident occurs in the system and to share information concerning common vulnerabilities and threats. This capability should assist the organization in pursuing appropriate legal action if necessary. Documentation should address reporting requirements for security incidents and actions to be taken.

2.2.4.4.3.5. Configuration Management Plan: Describes the change management control or configuration control procedures. These procedures should identify and document the functional and physical characteristics of the system, control changes to those characteristics, and record and report change processing and implementation status.

2.2.4.4.3.6. Security Features Users Guide: Describes the User/Employee duties and responsibilities for security while using your network and consequences if they fail to follow the policies.

2.2.4.4.3.7. Trusted Facility Manual (TFM): Documents the cautions and privileges necessary to control the operations of a secure facility, and provides the procedures for managing system audits. Describes audit procedures, records, and actions associates with various types of audit events. The TFM focuses on system administration, not on computer security in general. The document briefly describes the system, details security mechanisms in place and defines procedures to securely administering the system. The document also discusses the philosophy of the system security design and control. The TFM describes security operations and roles and responsibilities associated with system administration.

2.2.4.4.3.8. Security Test Plan, Procedure and Results: This appendix describes both the expected and actual test outcomes for the security mechanisms or features, at both the system and application level. All security features must be tested at both the system and application level; this includes Audit, Discretionary Access Control, and Identification and Authentication, and Object Reuse. Test documentation describes the test plan; test logs, test reports, test procedures, and test results and explains how the security mechanisms were functionally tested.

2.2.4.4.3.9. Security Policy: This appendix does not have to be a separate document, but can be part of the core SSAA. This section describes what is and is not permitted in the field of security during the general operation of the system. The security policy section describes the exceptions to the policies contained in the laws, regulations, rules, and practices that regulate how an organization manages, protects, and distributes information. This section establishes policy precedence when more than one policy applies. A list of polices that apply to the system is provided. The primary thrust of this section is to develop mission-level security objectives through deductive reasoning. Security objectives are the top-most level of

specifications and focus on the security related aspects of the identified mission. Security objectives must be concise, declarative sentences derived from analysis of mission information, threat, and umbrella security guidance. These security objectives should be written in terms independent of architecture and implementation. Each security objective should be justified by rationale. The rationale documents the mission objectives supported by that security objective, the threat driving the security objective, the consequences of not implementing the objective, and applicable umbrella security guidance supporting that security objective. The rationale binds each security objective to a mission objective and focuses attention on security at the mission level.

2.2.4.4.3.10. Memorandum of Agreement(s): This appendix contains all required memoranda of agreement (MOA). When systems managed by different DAAs are interfaced or networked, a MOA is required that addresses the accreditation requirements for each system involved. The MOA should include description and classification of the data, clearance levels of the users, designation of the DAA who shall resolve conflicts among the DAAs, and safeguards to be implemented before interfacing the systems. MOAs are required when one DoD component's system interfaces with another system within the same DoD component or in another DoD component and when a contractor's system interfaces with a DoD component's system or to another contractor's system.

2.2.4.4.3.11. Personnel Security Controls: This appendix provides a statement indicating the responsible organization complies with the appropriate personnel security requirements.

2.2.4.5. All electronic transmission of medical records and data over public unprotected and unapproved paths must be protected with FIPS 140-1 validated encryption technology that is interoperable with the DoD Public Key Infrastructure (PKI).

2.2.4.6. The Designated Approval Authority (DAA) as defined by the Lead Agent will serve as the accreditation official for Contractor information technology systems processing government sensitive but unclassified information.

2.2.4.7. All Contractor AISs, including stand-alone personal computers and laptops, that process government sensitive but unclassified information will be protected at the highest level of sensitivity of information processed, stored, transmitted, or accessed.

2.2.4.8. The Contractor shall establish and maintain standing operating procedures for safeguarding the security of the all sensitive but unclassified information, including privileged patient medical information and information subject to the Privacy Act, 1974, at a reasonable level of protection to preclude inadvertent disclosure to unauthorized sources.

2.2.4.9. These procedures shall include system auditing and routine review of audits, security awareness training, appropriate management of all system accounts and passwords, and providing access only to authorized personnel.

2.2.4.10. The Government reserves the right to specify what Government data/ information may be accessed by the Contractor. If at any time, classified national security information is discovered, a security breach is discovered, or unsuccessful attempts to access unauthorized information are noted, the Contractor shall secure the information and report the incident to the appropriate government representative.

2.2.4.11. The Contractor shall implement all required network security safeguards to protect the Contractor's AIS and sensitive information from unauthorized access, modification, or damage.

2.2.4.12. Specifically the Contractor shall implement network security measures to prevent unauthorized access via the Internet / DISN WAN and obtain certification and accreditation of the Contractor furnished network IAW DoD 5200.40 (DITSCAP), and the Information Assurance Technology Framework Forum (IATFF) ensuring compliance with the DoD Defense in Depth initiative.

2.2.4.13. The Contractor shall implement security measures to protect the system and data resources, procedures to react to Computer Emergency Response Team (CERT) security notices, and procedures designed to detect and correct security vulnerabilities.

2.2.4.14. All government provided information, or information relating to government sponsored personnel, that comes into the custody of the contractor remains the property of the U.S. Government and shall either be returned to the government or destroyed when directed by the appropriate government representative.

2.2.4.15. Personnel Security:

2.2.4.15.1. The contractor shall comply with the requirement to obtain the minimum personnel security investigations as prescribed by DoDD 5200.2-R based on the individual's responsibilities and access to sensitive but unclassified information.

2.2.4.15.2. This directive prescribes the level of security investigation required and the process for obtaining these security investigations.

2.2.4.15.3. All contractor personnel who have access to systems processing, storing, or transmitting sensitive but unclassified medical information shall be classified as ADP-I, ADP-II, or ADP-III as defined in DoDD 5200.2-R as dictated by their level of responsibility.

2.2.4.15.4. This classification determines the type of security investigation required.

2.2.4.15.5. Once personnel classification is determined, the appropriate investigation forms, finger print cards, and questionnaires shall be completed as required and submitted to the assigned Government AIS Security Officer for processing.

2.2.4.15.6. The appropriate government representative may authorize contractor personnel to temporarily occupy non-critical sensitive positions pending completion of the National Agency Check (NAC).

2.2.4.15.7. If at any time the individual receives unfavorable NAC adjudication, or if at any time information that would result in an unfavorable NAC becomes known, the Contractor shall immediately remove the employee from the non-critical-sensitive position.

2.2.4.15.8. All contractors and contractor sponsored personnel accessing Government systems are required to sign a non-disclosure agreement that will be retained as an official permanent record as determined by the sponsoring activity.

2.2.4.15.9. Security files on all Contractor personnel assigned to the contract shall be maintained by the contractor and made accessible to the appropriate government representative's Security Manager as required.

2.2.4.15.10. The Contractor shall report possible adverse information on contract employees occupying non-critical-sensitive positions through the ACOR to the appropriate government representative Security Manager.

2.2.5. Security activities are part of an ongoing process, even after certification and accreditation (C&A). Systems, processes, and personnel security must be maintained in accordance with DITSCAP and C&A approval packages. The Contractor will notify their Contracting Officers if / when they become aware of major modifications to their systems that may impact on their certification and accreditation.

CHAPTER 2

TRICARE ENCOUNTER DATA (TED)

SECTION SUBJECT

DRAFT

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CHAPTER 2
SECTION 1.1

DATA REPORTING - TELEPROCESSING REQUIREMENTS

1.0. GENERAL

The common means of communication between TMA and the contractor for sending and receiving data is a teleprocessing connection. An alternate method may be approved by TMA if there are good reasons to do so. Each contractor on the telecommunication network is responsible for furnishing to TMA at the start-up planning meeting (and update when a change occurs), the name, address, and telephone number of the person who will serve as the technical point of contact on teleprocessing matters. Contractors shall also furnish a separate computer center number to TMA which the TMA computer operator can use for resolution of problems related to data transmissions.

2.0. DATA COMMUNICATION TECHNICAL REQUIREMENTS

2.1. Network Communication Requirement

2.1.1. NIPRNET/INTERNET Connectivity from Contractor to TMA

All network traffic will be via TCP/IP. The government will arrange for NIPRNET connections to the contractors where feasible; otherwise, the public internet will be used. Government approved encryption will be used for all traffic between Contractor and TMA. Traffic from providers to contractors, among contractors, and between contractors and other health plans will follow encryption/security standards as required by HIPAA. The contractor is responsible for providing internal network connectivity to this TCP/IP data communication link.

2.1.2. Circuits

Circuits shall be ordered and maintained by TMA.

2.2. Front End Processor (FEP) Requirements

Depending on the services required by the contractor, the following ports must be provided by the contractor.

2.2.1. Integrators shall ensure that interactive traffic has highest priority during normal work hours. (Lights out, automated file transfer technology shall be implemented wherever practical. Human intervention and initiation shall be eliminated to every extent possible. This approach is intended to increase reliability, reduce potential for human error, maximize line utilization, minimize impacts on interactive sessions, and enhance operational efficiency.)

2.3. Communication Protocol Requirements

2.3.1. File transfer and distributed systems applications support software shall be provided by the government. This software is to support communications with the TMA data processing center. CONNECT:Direct (formerly Network Data Mover and hereafter referred to as NDM with the TCP/IP option) is the communications software in use. The contractor must provide this product and a platform capable of supporting this product with the TCP/IP option included. Details on this product can be obtained from:

Sterling Software
Communications Software Division
2477 Gateway Drive
Irving, TX 75063-2728
Phone: 703-264-8404

2.3.2. For interactive session support, TCP/IP communications software incorporating the application TN3270 shall be provided by the contractor.

2.4. Maintenance and Troubleshooting

2.4.1. Troubleshooting shall be initiated, either by the government or contractor, for government provided communications equipment. The contractor must provide a POC for this function to the TMA.

2.4.2. The contractor shall be responsible for troubleshooting and maintaining government provided communications equipment, at the contractor site.

2.4.3. Maintenance for the circuit and government provided communications equipment shall be the responsibility of the government. The government shall provide a POC for local repairs.

2.4.4. At the discretion of the contractor, backup communications equipment will be provided to support contractual claim cycle requirements and interactive transaction traffic. The public Internet will be used as the backup transmission vehicle.

3.0. DATA TRANSMISSION FORMAT REQUIREMENTS

3.1. CONNECT:Direct

3.1.1. A variety of TMA applications shall utilize the CONNECT:Direct communications software.

3.1.2. CONNECT:Direct does not restrict record lengths or record formats, destination media between host processors, etc. Data conversions occur automatically between platforms founded in ASCII or EBCDIC.

3.1.3. File organization, record formats, edit specifications, and report formats related to a particular application are identified under appropriate portions of this manual. Reference Chapter 1, Section 2 for record formats, and appropriate, corresponding chapters for edit requirements associated to specific elements within the record formats submitted to TMA.

3.1.4. Transmission size is limited to any combination of 250,000 records at one time.

3.2. Security

The goal of TMA security administration is to minimize maintenance of user-IDs and passwords across the network and to accommodate future security strategies through current procedures. All contractors shall comply with HIPAA security requirements.

3.2.1. Remote User Access to TMA

TMA shall implement Point Of Entry security in its communications with all remote sites. The network administrator at each remote installation shall contact the TMA network administrator to provide the local user-ID(s), name(s), and telephone number(s) of each individual requiring access to TMA. The TMA network administrator shall use the CONNECT:Direct authorization facility to relate the user id provided by the remote site to an internal user id and password at the TMA data processing installation. System Node ID (SNODEID) overrides shall not be permitted. Three advantages are derived through Point Of Entry implementation:

3.2.1.1. The remote user need not be concerned with changing passwords at frequent intervals;

3.2.1.2. Potential security breaches through hardcoded passwords are eliminated; and

3.2.1.3. Remote user access to CONNECT:Direct can be granted / retracted simply and quickly. The internal user id at TMA shall be highly restricted to standardized high level qualifiers, and shall not have TMA or batch access.

3.2.2. TMA Access to Remote Installations

Remote installations shall not require secondary node userid / password from TMA CONNECT:Direct users for the same reasons mentioned above. In those instances where userid / password is in use or planned, a similar security strategy is recommended.

3.3. "As Required" Transfers

Ad hoc movement of data files shall be coordinated through and executed by the network administrator or designated representative at the source file site. Generally speaking, the requestor needs only to provide the point of contact at the remote site, and the source file name. Destination file names shall be obtained from the network administrator at the site receiving the data. Compliance with naming conventions used for recurring automated transfers is not required. Other site specific requirements, such as security constraints and pool names are generally known to the network administrators.

4.0. TRANSMISSION DEVELOPMENT

A pure TCP / IP lights out implementation is the ultimate goal of all automation efforts pertaining to the communications software by eliminating human intervention, and providing reliable and smooth automated interfaces to applications at each site involved. Ideally, the generation, movement, utilization, processing, and reporting of data between

remote systems is intended to become virtually transparent. Functional specifications requiring manual input are highly discouraged. In order to facilitate this concept, the contractor shall implement, wherever possible, the TMA file naming convention for data files distributed over the TMA network. To have successful automated processes, all the following must be addressed:

4.1. File Naming Convention

4.1.1. All files received by and sent from the TMA data processing site shall comply with the following standard when using CONNECT:Direct:

4.1.1.1. First high level qualifier: OCH.

4.1.1.2. Second high level qualifier: NW. (production only) NWT. (systems integration test)

4.1.1.3. Third high level qualifier: variable application name assigned by TMA network administration. (not to exceed four characters)

4.1.1.4. Remaining qualifiers: variable per application needs.

4.1.2. The Contractor:

4.1.2.1. Shall retain source files transmitted over the communications network, to enable immediate isolation and identification for retransmission of the same dataset, for at least seven days. This does not alleviate other data retention requirements imposed by TMA.

4.1.2.2. Is highly encouraged to provide for utilization of the above naming convention standard on their own system for any data files involved in communications with TMA, but is not required to do so when the file being submitted to or retrieved from TMA's input by the contractor to the communication software's automated and standardized processes by variable parameter.

4.2. Centralization

TMA shall provide the automated process(es) required for implementation of a communications application, with the exception of site specific functions that vary from one site to another due to implementation of the software's capabilities. An example would be signon / signoff statements for DMBATCH methodologies implemented at that site.

4.3. Standardization

The contractor shall be afforded the opportunity to provide design and concept input prior to development and implementation of standardized communications processes for each application. Additional instructions pertaining to communications development may be found in the TMA standards.

4.4. Process Language

Since the effect of communications impacts multiple systems at the contractors and at TMA, all automated processes shall be developed by network administration personnel. Individuals assigned to this function shall be knowledgeable of the capabilities of the software. A network primary and secondary point of contact must be designated at each site (contractors / TMA) to coordinate development, integration, and modification. These individuals shall also be responsible for testing, implementing, monitoring, analyzing error situations, and resolving problems pertaining to communications functions.

4.5. Timing

Telecommunication transfers during normal business hours may be adversely affected by normal processing. Therefore, every attempt shall be made to maximize utilization of telecommunications lines by deferring transfers to night-time operation.

4.6. Frequency

Ideally, data would be accumulated at the source site throughout the workday, with a single file being transmitted at night. However, there are no restrictions on the number of files that may be transmitted in a single day.

4.7. Initiation

Under most circumstances, the source file site shall initiate automated processes to cause transmission to occur. With considerations for timing and frequency, activation of transfers for each application shall be addressed on a case by case basis.

4.8. Remote Systems Integration Testing Requirements

In addition to the actual movement of data between two sites, the application interface at each site is a critical piece of automation that severely impacts the success and / or failure of data communications. Interface to distributed applications may be automated, and is highly encouraged wherever practical.

4.8.1. Integration testing of the applications generating the source file(s) and utilizing the file(s) after transmission is required. These tests shall address at a minimum:

4.8.1.1. CPU and communications systems non-availability in excess of 24 hours,

4.8.1.2. Scheduled systems maintenance and IPL at each site,

4.8.1.3. Isolation of communications functions versus applications processing of data files, especially in respect to delays involving communications,

4.8.1.4. Monitoring of active lines / definitions,

4.8.1.5. Reasonable lead times for source file preparation,

4.8.1.6. Automatic initiation of source and destination file processing, and,

4.8.1.7. Adequacy of restart/recovery settings.

5.0. TRANSMISSION ENVIRONMENT

5.1. Telecommunications Queue (TCQ)

Management of communications functions shall be accommodated primarily through the software's TCQ. To avoid inadvertent loss of communications processes in progress, warm start is recommended for specification in the CONNECT:Direct initialization parameters.

5.2. Parallel Session Support

A minimum capability of 2 (two) parallel sessions between a remote site and TMA is requested, but not required. It is assumed that network administration staffs at each site shall configure and tune the environment for maximum performance and balance between all nodes in their network.

6.0. CONTINGENCY ACTION PLAN

If the contractor or TMA is unable to teleprocess data due to mechanical failure or natural disaster and repair time is expected to exceed 24 hours, the involved parties shall immediately transmit the data by shipping a magnetic tape. The contractor or TMA is responsible for immediately contacting the other in the event of any condition which would preclude teleprocessing data within the established schedule. The primary points of contact shall be the TMA computer operator and the contractor computer operator. The secondary points of contact shall be the persons designated by the contractor for teleprocessing matters and by TMA Contractor Support/CEIS Liaison. The contractor and TMA are responsible for providing each other the appropriate phone numbers and names.

6.1. Magnetic Tape Processing

Except in teleprocessing network failure (see above), only those contractors with permission from TMA will submit their data via magnetic tape. All contractors, however, must be able to send and receive data via mailed magnetic tape.

6.2. Tape Characteristics

Tape characteristics will be provided by TMA at a later date.

6.3. External Label

The contractor must identify the tape as a TMA tape and the external label must list the name of the contractor, the contractor number, the dataset name, file name (see above), block size, and record count.

6.4. Shipping Instructions

All tapes shall be shipped to TMA, c/o Defense Enterprise Computing Center (DECC), 6760 East Irvington Place, Denver, CO 80279-8000. Shipments shall be made by

means of transportation that assures secure and overnight delivery. Tapes must be packaged for shipment in cushioned envelopes or containers.

CHAPTER 2
SECTION 1.2

DATA REPORTING - TRICARE ENCOUNTER DATA RECORD SUBMISSION

1.0. GENERAL

1.1. TRICARE Encounter Data (TED) Records provide detailed information for each treatment encounter and are required for TMA statistical and financial reporting. A TED Record consists of either an institutional or non-institutional record. An institutional TED Record is defined as the submission of treatment encounter data created by the formal acceptance by a hospital or other authorized institutional provider of a TRICARE beneficiary for the purpose of occupying a bed with the reasonable expectation that the patient will remain on inpatient status at least 24 hours with the registration and assignment of an inpatient number or designation.

1.2. All elements of the TED records must be maintained in the contractor's claims history file. The claims history will reflect the data submitted to TMA on the TED Record including resubmissions and adjustments; it will also contain all data necessary to reproduce a TED record as required by this manual and to reproduce an EOB, if required.

1.3. All other treatment encounter data including institutional care in connection with ambulatory surgery must be reported on a non-institutional TED Record.

1.4. There are three types of TED Records:

1.4.1. Initial Submission

1.4.2. Adjustment Submission

1.4.3. Resubmission

1.5. These types of records are discussed briefly in the following paragraphs. Complete record layouts, data requirements by Element Locator Number (ELN), and edit criteria are detailed in Chapter 1, Section 2 through Section 8.

1.6. TED Records within a day's cycle are processed by TMA first in Filing Date order, then by TYPE OF SUBMISSION (I, O, D, R first; A, B, C, E second).

2.0. INITIAL SUBMISSION OF TED RECORDS

Initial submission applies only to the **first** submission of a **new** TED Record. Initial submissions are identified by TYPE OF SUBMISSION codes 'I', 'D', and 'O' on the TED Record.

2.1. All data indicated as "required" in the data element definition must be reported. If not received in the treatment encounter data, this data must be developed.

2.2. All signed numeric data elements on the initial submission must be reported as positive values.

2.3. When institutional TED Records are reported for other than the complete inpatient hospital stay, i.e. inpatient RTC care, the TED Records must be reported to TMA in the sequence that the care was provided (FREQUENCY CODES, 2-Initial, 3-Interim or 4-Final). If billings are submitted out of sequence the record submitted out of sequence will be provisionally accepted with the expectation that the missing portion of the stay will be submitted at a later date.

3.0. SUBMISSION OF ADJUSTMENT/CANCELLATION TED RECORDS

3.1. Adjustment submission applies to previously submitted and accepted TED Records which require adjustment because of processing errors or the need to update prior data with more current/accurate information. Adjustments are absolutely not permitted when the TYPE OF SUBMISSION on the initial TED Record was 'D' (Complete Contractor Denial).

3.2. Adjustment/Cancellation submissions are identified by TYPE OF SUBMISSION codes 'A', 'B', 'C', and 'E' on the TED Record. The use of the proper code is essential to accurate processing of adjustments.

3.3. Adjustment/Cancellation conditions include, but are not limited to, the following:

3.3.1. Error in information received from the provider or beneficiary

3.3.2. Late submission of data from providers

3.3.3. Error in processing by current or prior contractor (if applicable)

3.3.4. Deductible corrections

3.3.5. Successful recoupment of monies, or receipt of a refund from the provider, beneficiary, or third party

3.3.6. Stale dated payment checks

3.3.7. When heath care is charged to the wrong risk category (i.e., at-risk vs. not-at-risk) the original record will be cancelled and resubmitted under the correct risk category.

3.4. Adjustment submissions are **positive** (where additional monies are being paid by the contractor), **negative** (where monies are being credited back to the contractor), or **statistical** (serve to correct prior information but have no impact on payment amount).

Note: Adjustments to a complete denial TED Record are not permitted. Previously denied TED Records must be submitted as a new initial submission. If a negative adjustment results in complete cancellation of the amount paid by the government contractor, the adjustment must be reported with TYPE OF SUBMISSION codes 'C' or 'E'. Complete cancellation of

TYPE OF SUBMISSION 'O' (zero payment TED Record due to 100% reimbursement by other sources) is not permitted unless an adjustment TED Record(s) has been submitted with the net effect on AMOUNT PAID BY GOVERNMENT CONTRACTOR being greater than zero. Refer to "Examples" below for an example of a complete cancellation TED Record.

3.5. Examples of adjustment submissions are located below. Example paragraph 3.5.3.1. portrays a positive adjustment, example paragraph 3.5.3.2. portrays a negative adjustment, and example paragraph 3.5.3.3. portrays an adjustment correcting information without impact on payment amount.

3.5.1. All adjustment submissions must be reported using the TED INDICATOR reported on the initial submission TED Record, regardless of the number of adjustments to the initial TED Record. However, an adjustment that would result in submission of a different record category (e.g., change an institutional record, type 1, to a non-institutional record, type 2) is not permitted. In this instance, the initial TED Record must be completely cancelled (TYPE OF SUBMISSION code 'C'), and a new initial TED Record submitted with the correct data.

3.5.2. All data as reported on the initial TED Record must be resubmitted except for signed numeric fields, and those numeric fields requiring correction. Data contained within each line item in the variable portion of the adjustment TED Record must be reported in the same sequence, with the same LINE ITEM NUMBER as on the initial TED Record. An adjustment TED Record can add additional detail line items. All signed numeric fields and those non-signed numeric fields requiring correction must be reported according to the following:

3.5.2.1. All signed numeric data elements affected by the adjustment must reflect the **net difference** between what was **initially** reported and the **correct** amount. If adjustments were made in signed numeric fields prior to the current adjustment, the data elements must reflect the net amounts after combining the amounts in the initial and all prior adjustment submissions with this submission. Those signed numeric data elements that are unaffected by the adjustment netting process must be set to zero.

3.5.2.2. Numeric data elements requiring correction or update must reflect the most current information applicable to the service(s) being reported. All other numeric data elements must be reported as on the initial submission, or if prior adjustments corrected / updated the initial data, the data from the most recent submission must be reported.

3.5.2.3. Adjustment and complete cancellation TED Records are matched and applied to their corresponding initial submission TED Record and any other adjustment TED Records at TMA. The resulting "net" TED Record is edited through the TMA edit system as if it were an initial submission TED Record. Thus, the original and any prior adjustments must have passed TMA validity edits before a new adjustment is reported.

3.5.3. Examples

3.5.3.1. Positive Adjustment

A TED Record was submitted by the contractor and processed by TMA with an amount billed of $200.00, amount allowed of $100.00, and $50.00 applied to the deductible.

The amount allowed should have been $180.00 and no monies should have been applied to the deductible. The amount billed, however, was unchanged.

INITIAL TED RECORD POSITIVE ADJUSTMENT AMOUNTS

INITIAL TED RECORD	
Amount Billed	$200.00
Amount Allowed	100.00
Amount to Deductible	50.00
Amount Paid (75%)	37.50
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	80.00
Amount to Deductible	-50.00
Amount Paid (75%)	97.50
EFFECT AT TMA	
Amount Billed	200.00
Amount Allowed	180.00
Amount to Deductible	0
Amount Paid	135.00

3.5.3.2. Negative Adjustment

A TED Record was submitted by the contractor and processed by TMA with an amount billed of $500.00, an amount allowed of $500.00, and amount paid by the contractor of $500.00. However, other health insurance (OHI) was involved and their payment of $400.00 was recouped. The amounts billed and allowed were correct but the amount paid should have been $100.00.

TED RECORD NEGATIVE ADJUSTMENT AMOUNTS

INITIAL TED RECORD	
Amount Billed	$500.00
Amount Allowed	500.00
Amount to OHI	0
Amount Paid	500.00
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	0
Amount to OHI	400.00

TED RECORD NEGATIVE ADJUSTMENT AMOUNTS (CONTINUED)

Amount Paid	- 400.00
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Amount to OHI	400.00
Amount Paid	100.00

3.5.3.3. Statistical Adjustment

A TED Record was submitted by the contractor and processed by TMA for a hospitalization spanning twenty (20) bed days and $2,000.00 in billed charges. Fifteen (15) of the days were considered authorized. Subsequently, the total number of bed days was found to be thirty (30) and billed charges were actually $3,000.00. However, the allowable days and amount paid by the contractor remained unchanged.

TED RECORD STATISTICAL ADJUSTMENT

INITIAL TED RECORD	
Amount Billed	$2000.00
Amount Allowed	1500.00
Total Bed Days	20
Covered Bed Days	15
Amount Paid (75%)	1125.00
ADJUSTMENT TED RECORD	
Amount Billed	1000.00
Amount Allowed	0
Total Bed Days	10
Covered Days	0
Amount Paid	0
EFFECT AT TMA	
Amount Billed	3000.00
Amount Allowed	1500.00
Total Bed Days	30
Covered Days	15
Amount Paid	1125.00

3.5.3.4. Negative Adjustment (Complete Cancellation)

A TED Record was submitted by the contractor and processed by TMA with an amount billed of $500.00, allowed of $500.00, and amount paid by government contractor of $375.00. Subsequently, the contractor processed an adjustment to pay in full, reporting an increase of $125.00 in the amount paid by government contractor. The contractor then determined the care was processed in error and recouped the entire $500.00 payment.

TED RECORD NEGATIVE ADJUSTMENT

INITIAL TED RECORD	
Amount Billed	$500.00
Amount Allowed	500.00
Patient Coinsurance	125.00
Amount Paid	375.00
Total Bed Days	5
Covered Days	5
ADJUSTMENT TED RECORD	
Amount Billed	0
Amount Allowed	0
Patient Coinsurance	-125.00
Amount Paid	125.00
Total Bed Days	0
Covered Days	0
CANCELLATION TED RECORD	
Amount Billed	0
Amount Allowed	-500.00
Patient Coinsurance	0
Amount Paid	-500.00
Total Bed Days	0
Covered Days	-5
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	0
Patient Coinsurance	0
Amount Paid	0
Total Bed Days	5
Covered Days	0

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4.0. RESUBMISSION OF TED RECORDS

Resubmission applies to initial and adjustment TED Records which have failed to pass the TMA editing system. Records which fail validity edits will be rejected and returned to the contractor for correction and resubmission. Records which fail relational edits will be provisionally accepted and returned to the contractor for correction and resubmitted under a new voucher/batch, with the exception of header relational edits, they will be rejected and returned to the contractor for correction and resubmission. All returned records which fail the validity edits within a voucher must be returned by the contractor at the same time and balance to the outstanding Total Amount Paid and number of outstanding records at TMA. All returned records which fail the validity edits within a batch must be returned by the contractor at the same time and only balanced to the outstanding number of records. Upon resubmission, the records will again be processed through the TMA editing system. Resubmissions are identified by the RESUBMISSION NUMBER in the Header Record.

4.1. Resubmissions must be reported using the TED INDICATOR reported on the initial or adjustment TED Record, regardless of the number of times the TED Record is resubmitted.

4.2. All data as reported on the initial or adjustment TED Record must be resubmitted except for that data changed in order to correct the error(s).

4.3. If the rejected TED Record is TYPE OF SUBMISSION = I, report the correction TED Record with TYPE OF SUBMISSION = R (resubmission). All other TED Record TYPE OF SUBMISSION codes retain their original code throughout the resubmission process.

4.4. To liquidate or "clear" a voucher, both TOTAL AMOUNT PAID and the number of outstanding TED Records must zero out. When a TED Record passes editing, the TOTAL NUMBER OF RECORDS and the TOTAL AMOUNT PAID submitted on the original voucher are decremented. A voucher "clears" when both totals reach zero.

4.5. To liquidate or "clear" a batch, the number of outstanding TED Records must zero out through the edit error correction and resubmission process.

4.6. If TMA edits identify that the dollar amounts on the voucher are incorrect, the contractor must correct the related monetary data to balance to the AMOUNT PAID BY GOVERNMENT CONTRACTOR reported on the TED Record. **Do not change the AMOUNT PAID BY THE GOVERNMENT CONTRACTOR**. Correction of the payment error will be reflected through your processing and subsequent submission of the adjustment/cancellation TED Record.

5.0. INTERIM INSTITUTIONAL PAYMENTS

In certain cases, providers can submit interim bills for institutional claims. All TED Records for interim (interim or final) institutional bills must be submitted as an adjustment using the same ICN as the initial submission.

6.0. PROCESS FOR REPORTING RESOURCE SHARING AND CAPITATED TREATMENT ENCOUNTERS TO TMA

The following process is to be used by claims processors to submit data to TMA which relates to Resource Sharing or Capitated Treatment Encounters.

6.1. SPECIAL PROCESSING CODE

For Resource Sharing and / or Capitated claims / encounters, submit a TED Record which includes the appropriate SPECIAL PROCESSING CODE, as defined in Chapter 1, Section 2, for each patient encounter.

6.2. "Amount" Field Reporting

The "amount" fields must contain the following:

6.2.1. AMOUNT BILLED/AMOUNT BILLED BY PROCEDURE CODE

The AMOUNT BILLED / AMOUNT BILLED BY PROCEDURE CODE fields shall be the amount (institutional or noninstitutional charges) that the capitated provider would charge a patient on a capitated basis. If a Resource Sharing provider is being reimbursed on a fee-for-service basis with negotiated / discounted rates, report these amounts.

6.2.2. AMOUNT ALLOWED/AMOUNT ALLOWED BY PROCEDURE CODE

The AMOUNT ALLOWED / AMOUNT ALLOWED BY PROCEDURE CODE fields must contain the appropriate DRG or per diem for institutional services, the CHAMPUS Maximum Allowable Charge (CMAC) for noninstitutional services, or negotiated / discounted rates for both institutional and noninstitutional services.

6.2.3. AMOUNT PAID BY GOVERNMENT CONTRACTOR

The AMOUNT PAID BY GOVERNMENT CONTRACTOR field must equal the "lesser" of the amount allowed minus (PATIENT COST-SHARE plus AMOUNT APPLIED TOWARD DEDUCTIBLE) or AMOUNT ALLOWED minus amount of OHI. If the "Lesser" computed amount is negative, AMOUNT PAID BY GOVERNMENT CONTRACTOR must = $0.00.

7.0. PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA

The following process is to be used by claims processors to report claim-related data to TMA which contain charges for blood clotting factor.

7.1. Blood Clotting Factor

Data is to be reported on the Institutional TED Record, even though they are to be reimbursed separately from the DRG methodology.

7.2. Calculation of Charge

Charges will be calculated in a two-step process, as described below.

7.2.1. First Step

The DRG-reimbursable hospital charges will be calculated in the normal way. All related financial data will be stored for later use (see below).

7.2.2. Second Step

The blood clotting factor financial data will be calculated based on the reimbursement methodology described in the Policy Manual. All related financial data will be stored for later use. Revenue Code 636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor only. All other drugs are to be reported using the appropriate Revenue Codes in the 25X series.

7.2.2.1. The number to be coded in the UNITS OF SERVICE field is the number of units billed on the claim, not the number of payment units (which is 100 times the number of units billed).

7.2.2.2. The billed charges for blood clotting factor are to be reported in the TOTAL CHARGE BY REVENUE CODE field of the payment record.

Note: While blood clotting factor charges will be priced separately, the DENIAL REASON CODE cannot be 'F' (DRG non-reimbursables).

7.2.3. Data Reporting

From the two steps above, merge the financial data as follows, and enter them into the appropriate cost fields:

7.2.3.1. Amount Billed

This is the sum of all billed charges **including** those for blood clotting factor.

7.2.3.2. Amount Allowed

This is the sum of the two separate amounts allowed resulting from the calculations in step 2 above.

7.2.3.3. Amount of Other Health Insurance

This is the amount paid by other primary sources of reimbursement, if applicable.

7.2.3.4. Patient Cost-Share

Enter in the appropriate field based on the Category of Beneficiary:

7.2.3.4.1. Patient Cost-Share (For Other Than Family Members of Active Duty)

This is the amount based on either 25% of the billed charges (including those for blood clotting factor) or the per diem amount times the number of days in the hospital stay.

7.2.3.4.2. Patient Cost-Share (For Family Members of Active Duty)

This is the amount based on the inpatient hospital daily rate times the number of days in the hospital stay.

7.2.3.5. Amount Paid By Government Contractor

This is the sum of the two separate amounts resulting from the calculations in step 2 above.

CHAPTER 2
SECTION 1.3

DATA REPORTING - PROVIDER FILE RECORD SUBMISSION

1.0. GENERAL

1.1. Contractor Submission of Health Care Provider Records (HCPR) Requirements

1.1.1. Electronic Media Submission

Contractors are required to submit HCPR Records via electronic media to TMA for each provider who rendered care to TRICARE beneficiaries.

1.1.2. Record Content

1.1.2.1. Required Information for each Health Care Practitioner

1.1.2.1.1. A Unique Provider ID Number (PROVIDER TAXPAYER NUMBER)

1.1.2.1.2. Name

1.1.2.1.3. Address

1.1.2.1.4. Medical Specialty

1.1.2.1.5. Authorization Period

1.1.2.1.6. The provider must be authorized to provide care and be present on the Provider File at TMA to provide care on the date of service reported on the TED Record.

1.1.2.1.7. The data will be used by TMA to track services rendered by each provider.

1.1.3. Denied Services and Complete Cancellation

1.1.3.1. Services will be excluded from the date of service check. (Refer to Chapter 1, Section 2, for element descriptions and record layouts for the provider and the corresponding batch header records.)

1.2. Accountability for HCPRs

The contractor having contractual authority for provider certification in a given region has accountability for the HCPRs for providers in that region and is responsible for ensuring these HCPRs pass the TMA edits and for performing all maintenance transactions. This responsibility extends to those HCPRS submitted in support of the claims processing by another contractor *with the exception of pharmacy HCPRs which can be submitted by an contractor.*

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1.3. Data Submission

1.3.1. The data must be submitted according to the procedures presented in the Teleprocessing Requirements section of this chapter.

1.3.2. The contractor must provide a separate record for each provider who renders care to a TRICARE beneficiary.

1.3.3. For non-institutional providers, multiple records will be required when more than one provider is billing under the same TAXPAYER IDENTIFICATION NUMBER (e.g., clinics). In this case, the PROVIDER ZIP CODE and PROVIDER SUBIDENTIFIER must be used to identify unique providers. Refer to these elements for further instructions.

1.4. Institutional Providers that are Part of a Multi-Hospital Chain

1.4.1. Providers must be identified within the Taxpayer Identification Number (TIN) by the zip code.

1.4.2. In addition, multiple records will be required for institutional providers with both DRG-exempt and DRG-non-exempt units under the same TIN.

1.4.3. These are to be identified by the PROVIDER SPECIALTY / TYPE OF INSTITUTION. Only one (1) DRG-non-exempt TYPE OF INSTITUTION will be allowed per TIN and zip code, while multiple DRG-exempt types of facility will be allowed.

1.4.4. No duplicates within the TIN, PROVIDER ZIP CODE, and PROVIDER SPECIALITY / TYPE OF INSTITUTION will be allowed.

1.5. Institution Provides Outpatient Care

1.5.1. Additional provider records must be reported to TMA.

1.5.2. For outpatient services (e.g., ambulatory surgery in hospital, emergency room, hospital services), submit a provider record with PROVIDER SPECIALTY / TYPE OF INSTITUTION = 99 and INSTITUTIONAL OR NON-INSTITUTIONAL INDICATOR = N.

1.5.3. If the institution has a clinic associated with it, additional provider records must be reported to TMA using the PROVIDER SUBIDENTIFIER in the same manner as a stand alone clinic.

2.0. PROVIDER FILE RECORD MAINTENANCE

The Provider File is a dynamic file where records can be added, modified, or inactivated when a change is required.

2.1. File Submission

2.1.1. The contractor must submit transactions indicating the type of change and updated information.

2.1.2. Transactions will be submitted on an as needed basis.

2.1.3. Each group of transaction records must be preceded by a batch header record that identifies the subsequent records as provider transaction records. (Refer to data element Provider Subidentifier for examples of reporting clinics.)

2.2. Add Transactions

2.2.1. The TRANSACTION CODE must be 'A'.

2.2.2. All required data elements must be included.

2.2.3. An ADD cannot be made for institutional providers if the PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE, and PROVIDER SPECIALITY/TYPE OF INSTITUTION are already on file.

2.2.4. An ADD for non-institutional providers cannot be made if the PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE and PROVIDER SUBIDENTIFIER are already on file.

2.2.5. An ADD can be used to reactivate a provider key that has been inactivated.

2.3. Modify Transactions

2.3.1. The TRANSACTION CODE must be 'M'.

2.3.2. All required data elements must be included.

2.3.3. The MODIFY is used to make changes to an existing provider record, such as a termination of authorization or reauthorization.

2.3.4. A MODIFY will replace the previous record with a new record. Records being replaced will be held in history.

2.3.5. Multiple periods of authorization will automatically be stored on the TMA master provider file.

2.3.6. For institutional providers, a MODIFY will not be accepted if the PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE, and TYPE OF INSTITUTION are not already on the file.

2.3.7. PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE and PROVIDER SUBIDENTIFIER must be on the file for a non-institutional provider MODIFY transaction.

2.4. Inactivate Transactions

2.4.1. The TRANSACTION CODE must be 'I'.

2.4.2. The PROVIDER TAXPAYER NUMBER, PROVIDER SUBIDENTIFIER, PROVIDER STATE OR COUNTRY CODE, and PROVIDER ZIP CODE must be coded. These four data elements must match the same fields on the record at TMA to be inactivated.

2.4.3. Institutional Providers

The INACTIVATE process is to be used when there is an error on the PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE or TYPE OF INSTITUTION data elements.

2.4.4. Non-Institutional Providers

2.4.4.1. The INACTIVATE process is used when there is an error on either the PROVIDER TAXPAYER NUMBER, PROVIDER ZIP CODE or the PROVIDER SUBIDENTIFIER data elements.

2.4.4.2. To correct an error on these data elements, the incorrect record must be inactivated and the correct record added using two separate transactions.

2.4.4.3. When correcting an error on these data elements for a clinic, all provider records associated with the clinic must also be inactivated. This process also applies when replacing a record containing a contractor Assigned Provider Number (APN) with a record containing the actual Provider Taxpayer Number.

2.4.4.4. An inactive transaction can also be used to retroactively update the provider record (e.g. the RECORD EFFECTIVE DATE needed is prior to the previous RECORD EFFECTIVE DATE for the provider).

CHAPTER 2
SECTION 1.4

DATA REPORTING - PRICING FILE RECORD SUBMISSION

1.0. GENERAL

1.1. Contractors are required to submit TRICARE Encounter Pricing Records (TEPR) via electronic media to TRICARE Management Activity (TMA). Contractors are required to report applicable pricing data for all medical procedure codes for which a prevailing fee, by report or a conversion amount, has been developed. This must be done for each state in the contractor's region. This does not apply to unique network pricing arrangements or dental (ADA) procedures. Contractors shall not submit national prevailings on pricing file updates to TMA. The records contain required information for each procedure code including the state of care, an element identifying the type of procedure code, and detailed pricing information. Separate pricing records are submitted for area prevailing, by report, or conversion data. These data will be used by TMA to verify amounts paid on TED Records. (Refer to Chapter 2, Section 2 for element descriptions and record layouts for the pricing and corresponding batch header record).

1.2. The data must be submitted to TMA according to the procedures outlined in Chapter 2, Section 1.1. Initial submission of the pricing file must contain all procedures for which a price exists including by report.

2.0. PRICING FILE REPORTING REQUIREMENTS

Pricing records must be reported for logical data relationships. The following rules are to be used in building the Pricing File for reporting to TMA.

2.1. The 'key' to the Pricing File consists of PRICING STATE OR COUNTRY CODE, PROCEDURE CODE, CLASS OF PROVIDER, TYPE OF PRICING SERVICE, CATEGORY OF CARE FOR CONVERSION FACTOR, and PRICING PROFILE. No duplicates are allowed within this key.

2.2. Within each PRICING STATE OR COUNTRY CODE, and PRICING PROFILE, the following are the logical relationships for area prevailing records, including Medicare Economic Index (MEI) where applied:

LOGICAL RELATIONSHIPS FOR AREA PREVAILING RECORDS

PROCEDURE CODE RANGE	SURGERY	RADIOLOGY	PATHOLOGY	PSYCHIATRY	ALL OTHERS
Class of Provider	01,04	01,04	01,04	01,02,03	01,04
Type of Pricing Svc.	04,09	01,02,05	01,02,05	07,08	03

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Note: CATEGORY OF CARE FOR CONVERSION FACTOR must be blank on all area prevailing pricing records and CONVERSION AMOUNT must be zeros.

2.3. Within each PRICING STATE OR COUNTRY CODE, and PRICING PROFILE, the following are the logical relationships for conversion pricing records, including MEI, where applied:

LOGICAL RELATIONSHIPS FOR CONVERSION PRICING RECORDS

PROCEDURE CODE RANGE	SURGERY	RADIOLOGY	PATHOLOGY	PSYCHIATRY	ALL OTHERS
Class of Provider	01,04	01,04	01,04	01,02,03	01,04
Type of Pricing Svc.	04,09	01,02,05	01,02,05	03	03
Category of Care for Conversion Factor	S,A,B	R,B	P,B	M,B	M,B

Note: CONVERSION AMOUNT must be zeros on 'By Report' pricing records.

3.0. PRICING FILE RECORD MAINTENANCE

3.1. The contractor's complete pricing file must be submitted on an annual basis (1 January). No pricing records will be accepted at any other time.

CHAPTER 2
SECTION 2.1

DATA REQUIREMENTS - OVERVIEW

1.0. This chapter covers TMA requirements for the presentation of data submitted by the contractor. It specifies the structure of files and records to be sent to TMA for editing and processing. It also gives a complete definition of each data element included in these records. The data element definitions are sequenced within a given record type in alphabetical order by data element name. Data element definition forms, used for consistent presentation of each element, include element characteristics and parameters needed by the contractor for accurate submission of data required by TMA. Every data element is assigned an Element Locator Number (ELN) according to the following structure:

1.1. One-digit Record Category (followed by a hyphen):

0 - Batch Header (includes vouchers for ELN assignment)

1 - Institutional

2 - Non-Institutional

3 - Provider

4 - Pricing

1.2. Three-Digit Element Locator Number For A Given Record Category

2.0. Each data element definition identifies all records that contain the element and the error codes generated by the TMA editing system which validates data. To facilitate locating of data element definitions, the chapter includes an alphabetic index of all data elements.

3.0. A Batch Header record is to be used as the first record in each batch of Institutional, Non-Institutional, Provider and/or Pricing records. Contractors use Batch Header records for Provider and Pricing records and Batch/Voucher Header records for Institutional and Non-Institutional TED Records.

4.0. The Institutional record category is to be used primarily only when there is an inpatient admission to the institution. The Non-Institutional record category is to be used for submission of all other TRICARE Encounter Data Records, including outpatient maternity care rendered in an institution (cost-shared on an inpatient basis). The Provider record category is to be used to submit information for each provider who rendered care to TRICARE beneficiaries. The Pricing record category is to be used to submit information for pricing of non-CMAC procedures performed by providers who rendered care to TRICARE beneficiaries.

5.0. A data element "FILLER" has been included in all Logical Record Layouts to provide for future expansion of data elements.

6.0. The following editing rules will apply to all data elements unless the Data Element Definition contains different instructions. Validity and relational edits will be applied to all TED Records.

6.1. All numeric fields (including monetary fields) must be right-justified and zero-filled. Non-numeric values are not permitted. All numeric fields which do not contain data must be completely zero-filled. Fields identified as signed numeric fields will be processed by TMA as positive values unless the low-order position of the field indicates it contains a negative value. All money fields are signed numeric containing dollars and cents without the decimal point.

6.2. All alphabetic fields must be left-justified and blank-filled. A HEX 40 must be used to represent a blank. All alphabetic fields which do not contain data must be completely blank-filled.

6.3. All alphanumeric fields must be left-justified and blank-filled. A HEX 40 must be used to represent a blank. All alphanumeric fields which do not contain data must be completely blank-filled.

CHAPTER 2
SECTION 2.2

DATA REQUIREMENTS - DATA ELEMENT LAYOUT

1.0. BATCH/VOUCHER HEADER DATA ELEMENT

ELN	ELEMENT NAME	FORMAT	POSITION FROM	POSITION THRU
0-001	RECORD TYPE INDICATOR	X	1	1
0-005	CONTRACT IDENTIFIER		2	34
0-010	CONTRACT NUMBER	X(13)	2	14
0-015	BATCH / VOUCHER IDENTIFIER	X	15	15
0-020	BATCH / VOUCHER NUMBER		16	34
0-025	BATCH / VOUCHER ASAP ACCOUNT NUMBER	X(8)	16	23
0-030	BATCH / VOUCHER DATE	YYYYDDD	24	30
0-035	BATCH / VOUCHER SEQUENCE NUMBER	X(2)	31	32
0-040	BATCH / VOUCHER RESUBMISSION NUMBER	X(2)	33	34
0-045	TOTAL NUMBER OF RECORDS	9(7)	35	41
0-050	TOTAL AMOUNT PAID	S9(10)V99	42	53
0-055	INITIAL TRANSMISSION DATE (TMA DERIVED)	YYYYMMDD	54	61
0-060	TMA BATCH / VOUCHER PROCESSING DATE (TMA DERIVED)	YYYYMMDD	62	69
	FILLER	X(10)	70	79

2.0. INSTITUTIONAL DATA ELEMENT

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
1-001	RECORD TYPE INDICATOR	X	1	1
1-005	TED RECORD INDICATOR		2	25
1-010	INTERNAL CONTROL NUMBER (ICN)		2	18
1-015	FILING DATE	YYYYDDD	2	8
1-020	FILING STATE/COUNTRY CODE	X(3)	9	11
1-025	SEQUENCE NUMBER	X(7)	12	18
1-030	TIME STAMP	X(6)	19	24
1-035	ADJUSTMENT KEY	X	25	25
1-040	DATE TED RECORD PROCESSED TO COMPLETION	YYYYMMDD	26	33
1-045	DATE ADJUSTMENT IDENTIFIED	YYYYMMDD	34	41
1-050	SPONSOR SOCIAL SECURITY NUMBER	X(9)	42	50
1-055	SPONSOR PAY GRADE	X(2)	51	52
1-060	SPONSOR BRANCH OF SERVICE	X	53	53
1-065	SPONSOR STATUS	X	54	54
1-070	PATIENT RELATIONSHIP TO SPONSOR	X(2)	55	56
1-075	PATIENT NAME	X(27)	57	83
1-080	PATIENT SOCIAL SECURITY NUMBER	X(9)	84	92
1-085	PATIENT DATE OF BIRTH	YYYYMMDD	93	100
1-090	DEERS DEPENDENT SUFFIX	X(2)	101	102
1-095	PATIENT IDENTIFIER (RESERVED)	X(13)	103	115
1-100	PATIENT SEX	X	116	116
1-105	PATIENT ZIP CODE	X(9)	117	125
1-110	ENROLLMENT STATUS	X(2)	126	127
1-112	REGION INDICATOR	X(2)	128	129
1-115	PCM LOCATION DMIS-ID CODE	X(4)	130	133
1-120	AMOUNT BILLED (TOTAL)	S9(7)V99	134	142
1-125	AMOUNT ALLOWED (TOTAL)	S9(7)V99	143	151
1-130	AMOUNT PAID BY OTHER HEALTH INSURANCE	S9(7)V99	152	160
1-135	PATIENT COST-SHARE	S9(7)V99	161	169
1-140	AMOUNT PAID BY GOV'T CONTRACTOR (TOTAL)	S9(7)V99	170	178
1-145	INTEREST PAYMENT	S9(7)V99	179	187
1-150	REASON FOR INTEREST PAYMENT	X(2)	188	189
1-155	PROCESSING INFORMATION		190	220
1-160	OVERRIDE CODE	X(6)	190	195

2.0. INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION FROM	POSITION THRU
1-165	TYPE OF SUBMISSION	X	196	196
1-170	CA / NAS NUMBER	X(11)	197	207
1-175	CA / NAS REASON FOR ISSUANCE	X	208	208
1-180	CA / NAS EXCEPTION REASON	X(2)	209	210
1-185	SPECIAL PROCESSING CODE	X(8)	211	218
1-190	PRICING RATE CODE	X(2)	219	220
1-195	PROVIDER STATE OR COUNTRY CODE	X(3)	221	223
1-200	PROVIDER TAXPAYER NUMBER	X(9)	224	232
1-205	PROVIDER SUB-IDENTIFIER	X(4)	233	236
1-210	PROVIDER INDIVIDUAL NPI NUMBER (RESERVED)	X(10)	237	246
1-215	PROVIDER GROUP NPI NUMBER (RESERVED)	X(10)	247	256
1-220	PROVIDER ZIP CODE	X(9)	257	265
1-225	PROVIDER PARTICIPATION INDICATOR	X	266	266
1-230	PROVIDER NETWORK STATUS INDICATOR	X	267	267
1-235	TYPE OF INSTITUTION	X(2)	268	269
1-240	CLAIM FORM TYPE / EMC INDICATOR	X	270	270
1-245	TYPE OF BILL		271	272
1-250	FREQUENCY CODE	X	271	271
1-255	TYPE OF ADMISSION	X	272	272
1-260	SOURCE OF ADMISSION	X	273	273
1-265	ADMISSION DATE	YYYYMMDD	274	281
1-270	PATIENT STATUS	X(2)	282	283
1-275	BEGIN DATE OF CARE	YYYYMMDD	284	291
1-280	END DATE OF CARE	YYYYMMDD	292	299
1-285	COVERED DAYS	S9(3)	300	302
1-290	DRG NUMBER	X(3)	303	305
1-295	ADMISSION DIAGNOSIS	X(6)	306	311
1-300	PRINCIPAL TREATMENT DIAGNOSIS	X(6)	312	317
1-305	SECONDARY TREATMENT DIAGNOSIS-1	X(6)	318	323
1-310	SECONDARY TREATMENT DIAGNOSIS-2	X(6)	324	329
1-315	SECONDARY TREATMENT DIAGNOSIS-3	X(6)	330	335
1-320	SECONDARY TREATMENT DIAGNOSIS-4	X(6)	336	341
1-325	SECONDARY TREATMENT DIAGNOSIS-5	X(6)	342	347
1-330	SECONDARY TREATMENT DIAGNOSIS-6	X(6)	348	353

2.0. INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
1-335	SECONDARY TREATMENT DIAGNOSIS-7	X(6)	354	359
1-340	SECONDARY TREATMENT DIAGNOSIS-8	X(6)	360	365
1-345	PRINCIPAL OPERATION / NON-SURGICAL PROCEDURE CODE	X(5)	366	370
1-350	SECONDARY OPERATION / NON-SURGICAL PROCEDURE CODE-1	X(5)	371	375
1-355	SECONDARY OPERATION / NON-SURGICAL PROCEDURE CODE-2	X(5)	376	380
1-360	SECONDARY OPERATION / NON-SURGICAL PROCEDURE CODE-3	X(5)	381	385
1-365	SECONDARY OPERATION / NON-SURGICAL PROCEDURE CODE-4	X(5)	386	390
1-370	SECONDARY OPERATION / NON-SURGICAL PROCEDURE CODE-5	X(5)	391	395
	FILLER	X(20)	396	415
1-375	TOTAL OCCURRENCE / LINE ITEM NUMBER (OCCURS 1 TO 999 TIMES)	9(3)	416	418
1-380	OCCURRENCE / LINE ITEM NUMBER	9(3)	419	421
1-385	REVENUE CODE	X(4)	422	425
1-390	UNITS OF SERVICE BY REVENUE CODE	S9(7)	426	432
1-395	TOTAL CHARGE BY REVENUE CODE	S9(7)V99	433	441
1-400	DENIAL REASON CODE	X(2)	442	443
	FILLER	X(20)	444	463

3.0. NON-INSTITUTIONAL DATA ELEMENT

ELN	ELEMENT NAME	FORMAT	POSITION FROM	POSITION THRU
2-001	RECORD TYPE INDICATOR	X	1	1
2-005	TED RECORD INDICATOR		2	25
2-010	INTERNAL CONTROL NUMBER (ICN)		2	18
2-015	FILING DATE	YYYYDDD	2	8
2-020	FILING STATE/COUNTRY CODE	X(3)	9	11
2-025	SEQUENCE NUMBER	X(7)	12	18
2-030	TIME STAMP	X(6)	19	24
2-035	ADJUSTMENT KEY	X	25	25
2-040	DATE TED RECORD PROCESSED TO COMPLETION	YYYYMMDD	26	33
2-045	DATE ADJUSTMENT IDENTIFIED	YYYYMMDD	34	41
2-050	SPONSOR SOCIAL SECURITY NUMBER	X(9)	42	50
2-055	SPONSOR BRANCH OF SERVICE	X	51	51
2-060	PATIENT NAME	X(27)	52	78
2-065	PATIENT SOCIAL SECURITY NUMBER	X(9)	79	87
2-070	PATIENT DATE OF BIRTH	YYYYMMDD	88	95
2-075	DEERS DEPENDENT SUFFIX	X(2)	96	97
2-080	PATIENT IDENTIFIER (RESERVED)	X(13)	98	110
2-085	PATIENT SEX	X	111	111
2-090	PATIENT ZIP CODE	X(9)	112	120
2-095	OVERRIDE CODE	X(6)	121	126
2-100	TYPE OF SUBMISSION	X	127	127
2-105	CLAIM FORM TYPE/EMC INDICATOR	X	128	128
2-110	PCM LOCATION DMIS-ID CODE	X(4)	129	132
2-115	PRINCIPAL TREATMENT DIAGNOSIS	X(6)	133	138
2-120	SECONDARY TREATMENT DIAGNOSIS-1	X(6)	139	144
2-125	SECONDARY TREATMENT DIAGNOSIS-2	X(6)	145	150
2-130	SECONDARY TREATMENT DIAGNOSIS-3	X(6)	151	156
2-135	SECONDARY TREATMENT DIAGNOSIS-4	X(6)	157	162
	FILLER	X(10)	163	172
2-140	TOTAL OCCURRENCE/LINE ITEM NUMBER (OCCURS 1 TO 99 TIMES)	9(3)	173	175
2-145	OCCURRENCE/LINE ITEM NUMBER	9(3)	176	178
2-150	BEGIN DATE OF CARE	YYYYMMDD	179	186
2-155	END DATE OF CARE	YYYYMMDD	187	194
2-160	PROCEDURE CODE	X(5)	195	199

3.0. NON-INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION FROM	POSITION THRU
2-165	PROCEDURE CODE MODIFIER	X(4)	200	203
2-170	NATIONAL DRUG CODE	X(11)	204	214
2-175	NUMBER OF SERVICES	S9(2)	215	216
2-180	AMOUNT BILLED BY PROCEDURE CODE	S9(7)V99	217	225
2-185	AMOUNT ALLOWED BY PROCEDURE CODE	S9(7)V99	226	234
2-190	AMOUNT PAID BY OTHER HEALTH INSURANCE	S9(7)V99	235	243
2-195	AMOUNT APPLIED TOWARD DEDUCTIBLE	S9(3)V99	244	248
2-200	PATIENT COST-SHARE	S9(7)V99	249	257
2-205	AMOUNT PAID BY GOV'T CONTRACTOR BY PROCEDURE CODE	S9(7)V99	258	266
2-210	INTEREST PAYMENT	S9(7)V99	267	275
2-215	REASON FOR INTEREST PAYMENT	X(2)	276	277
2-220	DENIAL REASON CODE	X(2)	278	279
2-225	PROVIDER INDIVIDUAL NPI NUMBER (RESERVED)	X(10)	280	289
2-230	PROVIDER GROUP NPI NUMBER (RESERVED)	X(10)	290	299
2-235	PROVIDER STATE OR COUNTRY CODE	X(3)	300	302
2-240	PROVIDER TAXPAYER NUMBER	X(9)	303	311
2-245	PROVIDER SUB-IDENTIFIER	X(4)	312	315
2-250	PROVIDER ZIP CODE	X(9)	316	324
2-255	PROVIDER SPECIALTY	X(10)	325	334
2-260	PROVIDER PARTICIPATION INDICATOR	X	335	335
2-265	PROVIDER NETWORK STATUS INDICATOR	X	336	336
2-270	PHYSICIAN REFERRAL NUMBER	X(13)	337	349
2-275	PLACE OF SERVICE	X(2)	350	351
2-280	TYPE OF SERVICE	X(2)	352	353
2-285	SPONSOR STATUS	X	354	354
2-290	SPONSOR PAY GRADE	X(2)	355	356
2-295	PATIENT RELATIONSHIP TO SPONSOR	X(2)	357	358
2-300	ENROLLMENT STATUS	X(2)	359	360
2-303	REGION INDICATOR	X(2)	361	362
2-305	SPECIAL PROCESSING CODE	X(8)	363	370
2-310	CA / NAS NUMBER	X(11)	371	381
2-315	CA / NAS REASON FOR ISSUANCE	X	382	382
2-320	CA / NAS EXCEPTION REASON	X(2)	383	384
2-325	PRICING RATE CODE	X(2)	385	386

3.0. NON-INSTITUTIONAL DATA ELEMENT (CONTINUED)

ELN	ELEMENT NAME	FORMAT	POSITION FROM	POSITION THRU
	FILLER	X(20)	387	406

4.0. PROVIDER FILE RECORD

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
3-001	RECORD TYPE INDICATOR	X	1	1
3-005	PROVIDER TAXPAYER NUMBER	X(9)	2	10
3-010	PROVIDER SUB-IDENTIFIER	X(4)	11	14
3-015	PROVIDER TAXPAYER NUMBER IDENTIFIER	X	15	15
3-020	CONTRACTOR NUMBER	X(2)	16	17
3-025	PROVIDER CONTRACT AFFILIATION CODE	X	18	18
3-030	INSTITUTIONAL / NON-INSTITUTIONAL INDICATOR	X	19	19
3-035	PROVIDER NAME	X(40)	20	59
3-040	PROVIDER ADDRESS		60	119
3-045	PROVIDER STREET ADDRESS	X(30)	60	89
3-050	PROVIDER CITY	X(18)	90	107
3-055	PROVIDER STATE OR COUNTRY CODE	X(3)	108	110
3-060	PROVIDER ZIP CODE	X(9)	111	119
3-065	PROVIDER BILLING ADDRESS		120	179
3-070	PROVIDER BILLING STREET ADDRESS	X(30)	120	149
3-075	PROVIDER BILLING CITY	X(18)	150	167
3-080	PROVIDER BILLING STATE OR COUNTRY CODE	X(3)	168	170
3-085	PROVIDER BILLING ZIP CODE	X(9)	171	179
3-090	PROVIDER MAJOR SPECIALTY / TYPE OF INSTITUTION	X(10)	180	189
3-095	TYPE OF INSTITUTION CODE	X	190	190
3-100	AMERICAN HOSPITAL ASSOCIATION ID NUMBER	X(9)	191	199
3-105	AHA MULTI-HOSPITAL SYSTEM CODE	X(4)	200	203
3-110	MEDICARE NUMBER	X(8)	204	211
3-115	PROVIDER ACCEPTANCE DATE	YYYYMMDD	212	219
3-120	PROVIDER TERMINATION DATE	YYYYMMDD	220	227
3-125	RURAL / URBAN INDICATOR	X	228	228
3-130	IDME RATIO	S9(4)V9	229	233
3-135	IDME RATIO EFFECTIVE DATE	YYYYMMDD	234	241
3-140	AREA WAGE INDEX	S9(4)V9	242	246
3-145	AREA WAGE INDEX EFFECTIVE DATE	YYYYMMDD	247	254
3-150	DRG EXEMPT / NONEXEMPT INDICATOR	X	255	255
3-155	DRG EXEMPT / NONEXEMPT EFFECTIVE DATE	YYYYMMDD	256	263
3-160	TRANSACTION CODE	X	264	264
3-165	RECORD EFFECTIVE DATE	YYYYMMDD	265	272

Last Changed on 09/18/2001

4.0. PROVIDER FILE RECORD

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
	FILLER	X(17)	273	289

5.0. PRICING DATA RECORD

ELN	ELEMENT NAME	FORMAT	POSITION	
			FROM	THRU
4-001	RECORD TYPE INDICATOR	X	1	1
4-005	PRICING STATE OR COUNTRY CODE	X(3)	2	4
4-010	PROCEDURE CODE	X(5)	5	9
4-015	CLASS OF PROVIDER	X(2)	10	11
4-020	TYPE OF PRICING SERVICE	X(2)	12	13
4-025	PREVAILING FEE	S9(5)V99	14	20
4-030	CONVERSION AMOUNT	S9(5)V99	21	27
4-035	CATEGORY OF CARE FOR CONVERSION FACTOR	X	28	28
4-040	MEDICARE ECONOMIC INDEX PRICE	S9(5)V99	29	35
4-045	PRICING PROFILE	X(2)	36	37
4-050	PRICING EFFECTIVE DATE	YYYYMMDD	38	45
	FILLER	X(9)	46	54

6.0. TRANSMISSION RECORDS

6.1. The requirement for all electronic transmissions will incorporate the HIPAA mandated standards wherever feasible. These standards are being reviewed and will be incorporated in a future version.

6.2. The first record in each transmission to TMA, whether by teleprocessing or magnetic tape, will be a transmission header, using the following format. Where value is specified under comments, the value must be reported exactly as shown.

TRANSMISSION HEADER AND TRAILER RECORD FORMAT

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
1-8	Alpha	Data Type	Must be “TED Data”
9-10	**	Delimiter	Must be **
11-22	Alphanumeric	File Name	Must be named in accordance with Chapter 2, Section 1.1, paragraph 4.1.
23-24	**	Delimiter	Must be **
25-29	Alpha		Must be “FSIZE”
30-Variable	Numeric	File Size	Includes the total number of batch / voucher header records, provider, pricing and TED records (variable length). Includes transmission header, excludes transmission trailer.

TRANSMISSION HEADER AND TRAILER RECORD FORMAT (CONTINUED)

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
Variable (2 positions)	**	Delimiter	Must be **
Variable (6 positions)	Alpha	Record Type	Must be "RTYPEV"
Variable (2 positions)	**	Delimiter	Must be **
Variable (7 positions)	Alpha		Must be "MAXRLEN"
Variable	Numeric	Maximum Record Length	Length of the longest variable length record within the transmission. Must be > 0
Variable (2 positions)	**	Delimiter	Must be **
Variable- 80	Blank	Reserved	Must be HEX 40

6.3. Appended to the end of each transmission to TMA, whether by teleprocessing or magnetic tape, will be a transmission trailer record. The format for the transmission trailer record follows:

TRANSMISSION HEADER AND TRAILER RECORD FORMAT

POSITION(S)	DESCRIPTION	CONTENT	COMMENT
1	Alpha	Record ID	Must be "@" sign
2-3	Alphanumeric	Contractor Number	TMA-assigned Contractor number
4-10	Alphanumeric	Transmission Date	Enter in YYYYDDD format
11-14	Numeric	Batch Count	Number of batches and / or vouchers in the transmission
15-20	Numeric	Record Count	Includes the total number of batch / voucher header records, provider, pricing and variable length TED records. Excludes transmission header and transmission trailer
21-81	Blank	Reserved	Must be HEX 40

7.0. PRINT/REPORT TRANSMISSIONS

7.1. All errors in TED Records detected by the TMA editing system will be reported to the contractor in 133-byte record print image format. Except for special situations, these records will be teleprocessed to the contractor the day following processing. The format of the error records returned to the contractor will be:

ERROR RECORDS RETURNED FORMAT

DESCRIPTION	POSITION	
	FROM	THRU
Number of errors on this TED record	1	3
TED data as submitted	4	Variable
Error code number (occurs 1 to 500 times based on number of errors above)	Variable	Variable

The format of the error code number is 9 characters:

ERROR CODE FORMAT

DESCRIPTION	POSITION
ELN (Element Locator Number)	1 to 4
Sequenced number of error within ELN	5 to 6
Relational edit indicator if applicable	7 to 7
Line item from TED Record if applicable	8 to 9

CHAPTER 2
SECTION 2.3

DATA REQUIREMENTS - HEADER RECORD DATA

DATA ELEMENT DEFINITION

ELEMENT NAME:	**BATCH/VOUCHER ASAP ACCOUNT NUMBER**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-025	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters.
DEFINITION	This field is used to identify the ASAP Account[2] Number the voucher will be drawn from. Each year when new not-at-risk bank account(s) are setup by the contractor (per OPM Chapter 3, Section 2.), TMA will assign an 8 digit ASAP Account Number to draw funds from as checks clear the not-at-risk bank account(s).
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	VOUCHER NUMBER

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Zero fill except Institutional and Non-Institutional not-at-risk TED Records.**

[2] **Contractor must have "opened" an ASAP Account with TMA, CRM per OPM Chapter 3, Section 2.**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: BATCH/VOUCHER DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-030	1	Yes

PRIMARY PICTURE (FORMAT)	Seven (7) alphanumeric characters, YYYYDDD.	
DEFINITION	Date the contractor first created the batch/voucher for transmission to TMA. This date will not change through the resubmission process.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	DDD	3 digit Julian date
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	BATCH/VOUCHER NUMBER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

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Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: BATCH/VOUCHER IDENTIFIER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-015	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Identifies the type of records submitted in the batch/voucher.	
CODE/VALUE SPECIFICATIONS	3	Provider (Batch Only)
	4	Pricing (Batch Only)
	5	Institutional/Non-Institutional (Batch/Voucher)
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	CONTRACT IDENTIFIER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: BATCH/VOUCHER NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-020	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Field containing multiple elements that uniquely identify the batch / voucher.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
BATCH / VOUCHER DATE BATCH / VOUCHER SEQUENCE NUMBER BATCH / VOUCHER RESUBMISSION NUMBER	CONTRACT IDENTIFIER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**BATCH/VOUCHER RESUBMISSION NUMBER**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-040	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.
DEFINITION	Identifies the number of submissions for the batch / voucher.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	Set initial submission batch / voucher to 00 and increment by one (1) with each resubmission of rejected TED Records. Do **not** increment if resubmitting a batch / voucher that failed batch / voucher header edits.

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	BATCH / VOUCHER NUMBER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: BATCH/VOUCHER SEQUENCE NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-035	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.
DEFINITION	A sequential number assigned by the contractor to uniquely identify the batch / voucher. Once assigned, the number remains with the batch / voucher through resubmission process if applicable.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	Set initial sequence number to 01 and increment by one (1) for each subsequent batch / voucher for that date. Do not "reuse" sequence number within Contract Identifier.

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	BATCH / VOUCHER NUMBER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: CONTRACT IDENTIFIER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-005	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Field containing multiple elements that uniquely identify each batch / voucher of records submitted by the contractor.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
CONTRACT NUMBER BATCH / VOUCHER IDENTIFIER BATCH / VOUCHER NUMBER	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: CONTRACT NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-010	1	Yes

PRIMARY PICTURE (FORMAT)	Thirteen (13) alphanumeric characters.
DEFINITION	The unique 13 digit contract number assigned to a contract.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	CONTRACT IDENTIFIER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**INITIAL TRANSMISSION DATE (TMA DERIVED)**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Header	0-055	1	Yes[1]
PRIMARY PICTURE (FORMAT)	Eight (8) numeric characters, YYYYMMDD.		
DEFINITION	The Initial Transmission Date will be the date the contractor transmitted the voucher to TMA. **1. Voucher**: Once submission 00 has cleared, the Initial Transmission Received date **cannot** change, since this will be the date that TMA obligates the not-at-risk money and the date that will appear on the checks being issued to the providers/beneficiaries. **2. Batch**: This field will be zero filled.		
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Contractor must leave this field blank. Data will be populated and maintained by TMA.**

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Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**RECORD TYPE INDICATOR**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Header	0-001	1	Yes
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Code to indicate whether the record is a batch/voucher header or voucher header.		
CODE/VALUE SPECIFICATIONS	0	Batch Header (used on all Provider and Pricing batches, and for Institutional/Non-Institutional at-risk TED Records).	
	5	Voucher Header (used only for Institutional/Non-Institutional not-at-risk TED Records).	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	
NOTES AND SPECIAL INSTRUCTIONS: N/A			

DATA ELEMENT DEFINITION

ELEMENT NAME:	**TMA BATCH/VOUCHER PROCESSING DATE (TMA DERIVED)**		

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-060	1	No[1]

PRIMARY PICTURE (FORMAT)	Eight (8) numeric characters, YYYYMMDD.	
DEFINITION	The date the batch / voucher was processed by TMA.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Contractor must leave this field blank. Data will be populated by TMA.**

DRAFT

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**TOTAL AMOUNT PAID**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-050	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Twelve (12) signed numeric digits including two (2) decimal places.
DEFINITION	This field contains the total benefit dollars paid by the contractor and the interest paid for the TED Records contained in either the batch or voucher.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Must be zero filled for Provider and Pricing file batch header records.**

DATA ELEMENT DEFINITION

ELEMENT NAME: TOTAL NUMBER OF RECORDS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Header	0-045	1	Yes

PRIMARY PICTURE (FORMAT)	Seven (7) numeric digits.
DEFINITION	Total number of records submitted in the batch or voucher, exclusive of the header and trailer records. (Refer to Chapter 2, Section 2.2.)
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

CHAPTER 2
SECTION 2.4

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (A - D)

DATA ELEMENT DEFINITION

ELEMENT NAME:	**ADJUSTMENT KEY**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-035	1	Yes
Non-Institutional	2-035	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alpha character.
DEFINITION	Used only for an adjustment to a Non-TED Record. Contractor **MUST** submit the entire ICN for the adjusted Non-TED Record
CODE/VALUE SPECIFICATIONS	This value must be the same value as the HCSR suffix, as was present on the original submission.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	INTERNAL CONTROL NUMBER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: ADMISSION DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-265	1	Yes

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	Date the patient was first admitted to the institution for this episode.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

For complete claim denials when the appropriate value is not available use the same date as Begin Date of Care.

DATA ELEMENT DEFINITION

ELEMENT NAME: ADMISSION DIAGNOSIS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-295	1	Yes

PRIMARY PICTURE (FORMAT)	Six (6) alphanumeric digits.
DEFINITION	ICD-9-CM Code to identify diagnosis under which patient was admitted to institution.
CODE/VALUE SPECIFICATIONS	Refer to Internal Classification of Diseases Clinical Modification Edition 9, Volume 1 for valid ICD-9-CM codes. Must code the most detailed subcategory or subclassification. Left justify including leading zeros and blank fill. Do not fill with zeros. Do not code the decimal point.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

The primary diagnosis may be coded in lieu of the admission diagnosis if the admission diagnosis is not available and is not needed to support a waiver of the CA/NAS requirement for an emergency admission.

For complete claim denials when the appropriate value is not available use code 7999.

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT ALLOWED (TOTAL)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-125	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.
DEFINITION	Total amount allowed for all authorized services on the TED record. For reporting data relating to Resource Sharing and/or Capitated Treatment Encounters, refer to Chapter 2, Section 1.2, paragraph 6.0.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **If the complete TED Record is denied (TYPE OF SUBMISSION code 'D'), this amount must be zero.**

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Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT ALLOWED BY PROCEDURE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-185	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.
DEFINITION	Total amount allowed for this (these) service(s)/ supply(ies)
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **If the procedure is denied this amount must be zero.**

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT APPLIED TOWARD DEDUCTIBLE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-195	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Five (5) signed numeric digits including two (2) decimal places.
DEFINITION	Portion of Amount Allowed which is applied toward the patient or family deductible for the fiscal year on the TED Record.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	AMOUNT BILLED (TOTAL)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-120	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.
DEFINITION	Total amount billed for all services reported on the TED record. For reporting data relating to Resource Sharing and/or Capitated Treatment Encounters, refer to Chapter 2, Section 1.2, paragraph 6.0.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	Must be sum of all total charge per revenue code (institutional record) fields.

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**AMOUNT BILLED BY PROCEDURE CODE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Non-Institutional	2-180	Up to 99	Yes
PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimals.		
DEFINITION	Amount billed by the provider for this (these) service(s)/supply(ies).		
CODE/VALUE SPECIFICATIONS	N/A		
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-140	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.
DEFINITION	Portion of total amount allowed that was paid by government contractor for all services reported on the TED Record.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Reflects the total amount paid regardless of a provider's financial arrangement with the contractor, i.e., "withheld amounts."**

Note: THIS AMOUNT DOES NOT INCLUDE INTEREST PAYMENTS. The amount in this field will be included in the "TOTAL AMOUNT PAID" field in the header record.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**AMOUNT PAID BY GOVERNMENT CONTRACTOR BY PROCEDURE CODE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Non-Institutional	2-205	Up to 99	Yes[1]
PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.		
DEFINITION	Portion of amount allowed that was paid by government contractor for all services on this line item.		
CODE/VALUE SPECIFICATIONS	N / A		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Reflects the total amount paid regardless of a provider's financial arrangement with the contractor, i.e., "withheld amounts."**

Note: THIS AMOUNT DOES NOT INCLUDE INTEREST PAYMENTS. The amount in this field will be included in the "TOTAL AMOUNT PAID" field in the header record.

DATA ELEMENT DEFINITION

ELEMENT NAME: AMOUNT PAID BY OTHER HEALTH INSURANCE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-130	1	Yes
Non-Institutional	2-190	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.
DEFINITION	**Institutional**: Amount paid by other health insurance, including TPL, for all services reported. **Non-Institutional**: Amount paid by other health insurance, including TPL, for service(s) on this line item.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: BEGIN DATE OF CARE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-275	1	Yes
Non-Institutional	2-150	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	**Institutional**: Earliest date of care reported on this TED Record. **Non-Institutional**: The earliest beginning date of the provider's services for this procedure.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS EXCEPTION REASON

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-180	1	Yes[1]
Non-Institutional	2-320	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters[2].	
DEFINITION	Code that describes the reason for bypassing the requirement of a CA / NAS.	
CODE/VALUE SPECIFICATIONS	All contractors are required to process for CA / NAS for Inpatient Care.	
	Residing Within the Catchment Areas of All Uniformed Services Medical Facilities (DD Form 1251 **not required**)	
	1	Enrollment in an insurance plan that provides primary coverage
	2	Emergency medical treatment
	3	Inpatient care in a college infirmary
	4	Inpatient care in an approved nursing facility
	5	Residential Treatment Center
	6	Resource Sharing
	7	Specialized Treatment Facility, e.g., Alcohol Treatment Facility
	8	Heart Transplant
	9	TRICARE Demonstration Projects that allow exception to CA / NAS requirements.

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if applicable to TED Record as defined in CA/NAS Exception Reason Specifications. If not applicable, report blank.

[2] When using single digit codes, left justify and blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS EXCEPTION REASON (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	A	CA / NAS not required for the first 3 days of routine care for a newborn of: **1.** An active duty member; **2.** A mother whose OHI does not cover the newborn; **3.** An illegitimate child of an active duty sponsor.
	B	Former spouse with pre-existing condition, not on DEERS.
	C	Issuance of Good Faith Payment when the patient cannot be enrolled on DEERS due to death, inability to locate, etc.
	D	Delivery in a free standing birthing center or hospital outpatient birthing room
	E	Lung Transplant
	F	Combined Liver-Kidney Transplant
	H	Heart-Lung Transplant
	K	Continued Health Care Benefit Program (CHCBP)
	L	Hospice
	M	Abused Family Member
	O	Living-Related Donor Liver Transplant (prior to 06 / 01 / 1999)
	Q	Active Duty Claims
	R	Simultaneous Pancreas-Kidney Transplant

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if applicable to TED Record as defined in CA/NAS Exception Reason Specifications. If not applicable, report blank.

[2] When using single digit codes, left justify and blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS EXCEPTION REASON (CONTINUED)

CODE/VALUE SPECIFICATIONS (CONTINUED)	ORDER	CA/NAS EXCEPTION REASON	DESCRIPTION
	1st	9	TRICARE Demonstration Projects
	2nd	8	Heart Transplant
	3rd	E	Lung Transplant
	4th	F	Combined Liver-Kidney Transplant
	5th	2	Emergency medical treatment
	6th	1	Enrollment in an insurance plan that provides primary coverage
	7th	3	Inpatient care in college infirmary
	8th	4	Inpatient care in approved nursing facility
	9th	5	Residential Treatment Center care
	10th	6	Resource Sharing
	11th	7	Specialized Treatment Facility, e.g., Alcohol Treatment Facility
	12th	D	Delivery in a freestanding birthing center or hospital outpatient birthing room
	13th	A	Routine care for newborn of an active duty member

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if applicable to TED Record as defined in CA/NAS Exception Reason Specifications. If not applicable, report blank.

[2] When using single digit codes, left justify and blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS EXCEPTION REASON (CONTINUED)			
CODE/VALUE SPECIFICATIONS (CONTINUED)	**ORDER**	**CA/NAS EXCEPTION REASON**	**DESCRIPTION**
	14th	B	Former spouse with pre-existing condition, not on DEERS and CA/NAS required
	15th	C	Issuance of Good Faith Payment when the patient cannot be enrolled on DEERS due to death, inability to locate, etc.
	16th	L	Hospice
	17th	Q	Active Duty Claims
	18th	O	Living-Related Donor Liver Transplant
	19th	H	Heart-Lung Transplant
	20th	K	Continued Health Care Benefits Program (CHCBP)
	21st	M	Abused Family Member
ALGORITHM	N/A		

SUBORDINATE AND/OR GROUP ELEMENTS	
SUBORDINATE	**GROUP**
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if applicable to TED Record as defined in CA/NAS Exception Reason Specifications. If not applicable, report blank.

[2] When using single digit codes, left justify and blank fill.

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS REASON FOR ISSUANCE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-175	1	Yes[1]
Non-Institutional	2-315	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character. Download from DEERS.
DEFINITION	The CA / NAS Reason For Issuance indicates why the care was not or cannot be provided by a Military Treatment Facility.
CODE/VALUE SPECIFICATIONS	Submit in same format as DEERS response.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:
[1] **If not applicable report blanks.**

DATA ELEMENT DEFINITION

ELEMENT NAME: CA/NAS NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-170	1	Yes[1]
Non-Institutional	2-310	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Eleven (11) alphanumeric characters. Download field from DEERS (or from hardcopy if attached to claim).
DEFINITION	Unique number assigned by the MTF when issuing the CA / NAS. Care authorization is also issued by the MTF. Both numbers are carried on the DEERS database.
CODE/VALUE SPECIFICATIONS	Submit in same format as DEERS response.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if inpatient care and patient lives within a catchment area, and patient lives within a catchment area. Can be blank if the record is denied for lack of CA/ NAS, or TED Record contains treatment data exempt from CA/NAS requirement.**

DATA ELEMENT DEFINITION

ELEMENT NAME: CLAIM FORM TYPE/EMC INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-240	1	Yes
Non-Institutional	2-105	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code associated with the primary claim form submitted.	
CODE/VALUE SPECIFICATIONS	B	DD Form 2642
	C	HCFA Form 1500
	F	UB-92
	G	Electronic Institutional Claim Submission
	H	Electronic Non-Institutional Claim Submission
	I	Electronic Drug Claim Submission
	J	Other
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**COVERED DAYS**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Institutional	1-285	1	Yes
PRIMARY PICTURE (FORMAT)	Three (3) signed numeric digits		
DEFINITION	Number of hospital days authorized for all services within the TED Record.		
CODE/VALUE SPECIFICATIONS	Enter the number of hospital days where there was any allowance by the contractor. For admit through discharge statements, enter the number of hospital days where there was any allowance by the contractor. For initial, interim or final statement enter the number of allowed days in the period covered by the TED Record.		
ALGORITHM	The day of admission is to be counted as a hospital day. The day of discharge is not to be counted as a hospital day.		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	
NOTES AND SPECIAL INSTRUCTIONS: N/A			

DATA ELEMENT DEFINITION

ELEMENT NAME: DATE ADJUSTMENT IDENTIFIED

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-045	1	Yes[1]
Non-Institutional	2-045	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	Date the contractor determined an adjustment TED Record was required.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Zero fill if TED Record is not an adjustment.**

DATA ELEMENT DEFINITION

ELEMENT NAME: DATE TED RECORD PROCESSED TO COMPLETION

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-040	1	Yes
Non-Institutional	2-040	1	Yes

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	Date the contractor processed the claim / treatment encounter data to completion. This is when all services and supplies on the claim have been adjudicated, payment has been determined, deductible has been applied, checks and EOBs have been prepared for mailing, and payment / deductible / denial has been posted to history and the TED record(s).	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: DEERS DEPENDENT SUFFIX

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-090	1	Yes
Non-Institutional	2-075	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code maintained on DEERS database that uniquely identifies the patient within the family. Download field from DEERS.	
CODE/VALUE SPECIFICATIONS	DEERS Dependent Suffix	
	01-19	Eligible Dependent Children
	20	Sponsor
	30-39	Spouse of Sponsor
	40-44	Mother of Sponsor
	45-49	Father of Sponsor
	50-54	Mother-in-law of Sponsor
	55-59	Father-in-law of Sponsor
	60-69	Other Eligible Family Members (including former spouse)
	70-74	Unknown by DEERS
	75	Pseudo DDS - Unknown by Contractor
	98	Service Secretary Designee
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: DENIAL REASON CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-400	Up to 999	Yes[1]
Non-Institutional	2-220	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code identifying the reason for non-payment of services on the detail line item.	
CODE/VALUE SPECIFICATIONS	1	Duplicate service(s)
	2	Ineligible claimant
	3	Non-covered benefit/service
	4	Maximum benefit exceeded
	6	Filing limitation exceeded
	7	Suspense limitation exceeded
	8	Other
	9	CA/NAS cancelled or not provided
	A	DEERS
	B	Potential Third Party Liability
	C	Verified Third Party Liability
	D	Bone marrow transplant, no Wilford Hall referral
	E[2]	Billing for partial stay under DRG not reimbursable
	F[2]	DRG non-reimbursable (e.g., hospital based professionals, kidney acquisition costs)
	G	Authorization not on file

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if services are not allowed. Leave blank if not applicable.**
[2] **Institutional Only.**
[3] **Non-Institutional Only.**

DATA ELEMENT DEFINITION

ELEMENT NAME: DENIAL REASON CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	H	Invalid Interim DRG request for payment
	I	High Volume Psychiatric Hospital/Unit excluded from per diem reimbursement
	J	Billing medium incorrect; e.g., billing on a UB-92 for professional services/supplies.
	K	Maximum amount allowed for more comprehensive procedure
	L	Other insurance processing information not provided
	M	Provider is not TRICARE-certified
	N	Multiple denial reasons
	GG[3]	TRICARE Claimcheck
	LL[3]	TRICARE Claimcheck Laboratory
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if services are not allowed. Leave blank if not applicable.
[2] Institutional Only.
[3] Non-Institutional Only.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**DRG NUMBER**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Institutional	1-290	1	Yes[1]
PRIMARY PICTURE (FORMAT)	Three (3) alphanumeric digits.		
DEFINITION	Number identifying the Diagnosis Related Group (DRG) determined for this care.		
CODE/VALUE SPECIFICATIONS	N / A		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if TED Record is processed under TRICARE/CHAMPUS DRG reimbursement methodology.**

CHAPTER 2
SECTION 2.5

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (E - L)

DATA ELEMENT DEFINITION

ELEMENT NAME:	**END DATE OF CARE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Institutional	1-280	1	Yes
Non-Institutional	2-155	Up to 99	Yes
PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.		
DEFINITION	**Institutional:** Latest date of care reported on this TED Record. **Non-Institutional**: The latest ending date of the provider's services for this procedure.		
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	
NOTES AND SPECIAL INSTRUCTIONS: **N/A**			

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: ENROLLMENT STATUS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-110	1	Yes
Non-Institutional	2-300	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code indicating whether the patient is enrolled with the contractor (Prime) or not (Non-Prime), or the care was received under the Standard TRICARE Program, or a special care program.	
CODE/VALUE SPECIFICATIONS	**Enrollment Status**	
	T	TRICARE Standard Program
	U	TRICARE Prime, Civilian PCM
	V	TRICARE Extra
	W[1]	TPR Active Duty Claims - USA
	X[1]	Active Duty Member Claims - Europe
	Y[1]	Continued Health Care Benefit Program (CHCBP) Standard
	Z	TRICARE Prime, MTF / PCM
	AA[1]	Continued Health Care Benefit Program (CHCBP) Extra
	BB[1]	TRICARE Senior Prime (Effective 10/01/1998 through 12/31/2001
	FE[1]	TRICARE for Life - Extra (Effective 10/01/2001)
	FS[1]	TRICARE for Life - Standard (Effective 10/01/2001)
	PS[1]	TRICARE Senior Pharmacy (Effective 04/01/2001)

NOTES AND SPECIAL INSTRUCTIONS:

Left justify and blank fill.

Enrollment Status U shall be used for CONUS and also for TRICARE Overseas Program Prime enrollees.

[1] Not-At-Risk Payment By Contractor.

DRAFT

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**ENROLLMENT STATUS (CONTINUED)**	
	SN[1]	Supplemental Health Care Program - Non-MTF-Referred Care
CODE/VALUE SPECIFICATIONS (CONTINUED)	SR[1]	Supplemental Health Care Program - Referred Care
	SO[1]	Supplemental Health Care Program - Non TRICARE Eligible (Terminated 06/01/2001)
	ST[1]	Supplemental Health Care Program - TRICARE Eligible (Terminated 06/01/2001)
	TS[1]	TRICARE Senior Supplement Demonstration Program (Effective 04/01/2000)
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	**GROUP**
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

Left justify and blank fill.

Enrollment Status U shall be used for CONUS and also for TRICARE Overseas Program Prime enrollees.

[1] Not-At-Risk Payment By Contractor.

DRAFT

DATA ELEMENT DEFINITION

ELEMENT NAME: FILING DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-015	1	Yes
Non-Institutional	2-015	1	Yes

PRIMARY PICTURE (FORMAT)	Seven (7) alphanumeric characters, YYYYDDD.	
DEFINITION	Date the request for payment of services rendered was received by the contractor for processing.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year of receipt
	DDD	3 digit Julian date of receipt
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	INTERNAL CONTROL NUMBER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: FILING STATE/COUNTRY CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-020	1	Yes
Non-Institutional	2-020	1	Yes

PRIMARY PICTURE (FORMAT)	Three (3) alphanumeric characters.
DEFINITION	Code that indicates the State or Country where the primary care was provided.
CODE/VALUE SPECIFICATIONS	Refer to Chapter 2, Addendum A and Addendum B[1].
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	INTERNAL CONTROL NUMBER

NOTES AND SPECIAL INSTRUCTIONS:

[1] **State code will consist of 2 alphanumeric characters, which is left justified and blank fill to right. The foreign countries will consist of 3 alphanumeric characters.**

DATA ELEMENT DEFINITION

ELEMENT NAME: FREQUENCY CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-250	1	Yes[1]

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code that describes the frequency of billing from the institution. All TED Records for interim (interim or final) institutional bills must be submitted as an adjustment using the same ICN as the initial submission.	
CODE/VALUE SPECIFICATIONS	1	Admit thru Discharge TED Record
	2	Interim - Initial TED Record
	3	Interim - Interim TED Record
	4	Interim - Final TED Record
	7	Replacement of Prior Claim
	8	Void / Cancel of Prior Claim
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	TYPE OF BILL

NOTES AND SPECIAL INSTRUCTIONS:

[1] **The Initial, Interim, and Final TED Records, when used, must be submitted to TMA in correct sequence. If the patient is transferred and the care is processed under DRG rules, then Code '1' must be used; all other Transfers must use Code '1' or '4' as appropriate.**

For complete claim denials when the appropriate value is not available, use code 001; there is no default on DRG interim billings.

DATA ELEMENT DEFINITION

ELEMENT NAME: INTEREST PAYMENT

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-145	1	No
Non-Institutional	2-210	Up to 99	No

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.
DEFINITION	The interest field is used by the contractor to report / record any dollar amounts associated with the delivery of health care that could not otherwise be reported in existing TED records fields. This amount shall be reported on both at-risk and not-at-risk payments (batch / voucher). (Refer to OPM Chapter 3, Section 2)
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

Note: This amount is not part of the "AMOUNT PAID BY GOVERNMENT CONTRACTOR" field. However, it will be included in the "TOTAL AMOUNT PAID" field in the header record.

DATA ELEMENT DEFINITION

ELEMENT NAME: INTERNAL CONTROL NUMBER (ICN)

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-010	1	Yes
Non-Institutional	2-010	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	N/A
CODE/VALUE SPECIFICATIONS	Refer to subordinate element definitions.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
FILING DATE FILING STATE/COUNTRY CODE SEQUENCE NUMBER	TED RECORD INDICATOR

NOTES AND SPECIAL INSTRUCTIONS:
N/A

CHAPTER 2
SECTION 2.6

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

ELEMENT NAME:	**NATIONAL DRUG CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-170	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Eleven (11) alphanumeric characters.
DEFINITION	Number assigned to pharmaceutical products by the Food and Drug Administration (FDA).
CODE/VALUE SPECIFICATIONS	Unique number assigned to include pharmaceutical by the FDA.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Only required for Outpatient Drug claim.**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**NUMBER OF SERVICES**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-175	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Two (2) signed numeric digits.
DEFINITION	Number of procedures performed/services or supplies rendered for medical, dental, and mental health care.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	Identical procedures must be combined when performed by the same provider, with the same charge for each, and within the same calendar month, provided the reason for allowance/denial is the same for each charge. For ambulance services, allergy testing, DME rental, POV mileage for PFPWD, or anesthesiology, enter 01 for each service regardless of length of time, number of base units or mileage. Allowed prescription drugs must be combined separately from disallowed prescription drugs. For prescriptions report the number of prescriptions.

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: OCCURRENCE/LINE ITEM NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-380	Up to 999	Yes
Non-Institutional	2-145	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Three (3)[1] numeric digits.
DEFINITION	A unique number for each utilization/revenue data occurrence within the TED Record. Line item must be assigned in sequential ascending order.
CODE/VALUE SPECIFICATIONS	N/A
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Non-institutional will be limited to 99 occurrences.**

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-160	3	Yes[1]
Non-Institutional	2-095	3	Yes[1]

PRIMARY PICTURE (FORMAT)	Six (6) alpha characters.	
DEFINITION	The group of three codes which indicate that certain questionable data has been identified and approved by the contractor and the normal editing and processing rules should be bypassed for this record.	
CODE/VALUE SPECIFICATIONS	11	Claims retained by the contractor for development (information not available from in-house sources) (Effective 02/01/00)
	12	TPL claims requiring development (Effective 02/01/2000)
	13	Government intervention claims - pended up to 60 calendar days (Benefit Changes, CMAC updates, etc.) (Effective 02/01/2000)
	14	Claims requiring intervention by another contractor (Effective 02/01/2000)
	15	Claims pended at government direction 60 calendar days and over (Effective 02/01/2000)
	A	Patient is over 65
	B	Patient is a spouse under 12 years of age
	C	Good faith claim; payment has been made.
	D	Patient is family member 21 years of age or older

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if override code is applicable to override TMA edit checking. Can report 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two characters: left justify and blank fill**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	E	Diagnosis is maternity; patient is under 12 years of age
	F	Claim was filed after the filing deadline.
	G	Diagnosis / Procedure code for female; sex indicates male
	H	Diagnosis / Procedure code for male, sex indicates female
	I	Patient is a former spouse under 34 years of age
	J	Successive admission (patient is family member of an Active Duty Sponsor and cost-share is based on both current and prior admission) (Institutional Only)
	K	Catastrophic loss protection limit reached, patient cost-share and deductible rules do not apply
	M	NATO, Social Security Number not applicable
	N	Retrospective payment - Inpatient Mental Health (Institutional Only)
	P	Reserved (to be used only with TMA authorization)
	Q	Former Spouse with Pre-Existing Condition
	R	Patient date of birth is not consistent with procedure / diagnosis code age restricting; procedure performed due to medical necessity

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if override code is applicable to override TMA edit checking. Can report 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two characters: left justify and blank fill**

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	S	Zip code override to be used when: **1.** A beneficiary has moved out of a region and the contractor is still responsible for the care claimed; or **2.** If a beneficiary resides in a region different from the region they are enrolled in, but are within the same contract jurisdiction (i.e., 2/5, 3/4 or 9/10)
	U	Beneficiary indemnification payment
	V	Active Duty Family Member, services provided in TRICARE Europe
	Y	Newborn in mother's room without nursery charges (Institutional Only)
	Z	Enhanced benefit
	NC	Non-Certified Providers (does not include sanctioned/suspended providers)
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if override code is applicable to override TMA edit checking. Can report 1 to 3 codes, left justify and blank fill. Do not duplicate. Each code is two characters: left justify and blank fill**

CHAPTER 2
SECTION 2.7

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (P)

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PATIENT COST-SHARE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-135	1	Yes
Non-Institutional	2-200	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal place.
DEFINITION	**Institutional:** The total amount of money the beneficiary is responsible for paying in connection with covered services, other disallowed amounts. **Non-Institutional**: The total amount of money the beneficiary is responsible for paying in connection with covered services, other than the annual fiscal year deductible and any disallowed amounts.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT DATE OF BIRTH

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-085	1	Yes
Non-Institutional	2-070	1	Yes

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD. Download field from DEERS.	
DEFINITION	Date of birth of patient	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT IDENTIFIER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-095	1	No
Non-Institutional	2-080	1	No

PRIMARY PICTURE (FORMAT)	Thirteen (13) alphanumeric characters.
DEFINITION	Reserved for future use. Code maintained on DEERS database that uniquely identifies the patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT NAME

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-075	1	Yes
Non-Institutional	2-060	1	Yes

PRIMARY PICTURE (FORMAT)	Twenty-seven (27) alphanumeric characters.
DEFINITION	Name of patient. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT RELATIONSHIP TO SPONSOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-070	1	Yes
Non-Institutional	2-295	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric character.	
DEFINITION	Code that defines the relationship of the patient to the sponsor. Download field from DEERS	
CODE/VALUE SPECIFICATIONS	01	Spouse
	15	Ward of Court (includes foster and preadoptive children)
	17	Step Child
	19	Child (includes adopted)
	21	Unknown
	b	Sponsor
	F	Unremarried Widow(er)
	G	Unmarried Widow(er)
	H	Unmarried Former Spouse meeting 20/20/20 criteria
	L	Parent-in-law
	M	Step Parent-in-law
	P	Parent
	R	Unremarried Former Spouse divorced on or after 04/01/1985, meeting 20/20/15 criteria
	T	Unremarried Former Spouse
	U	Step Parent
	X	Other (includes good faith payments)

NOTES AND SPECIAL INSTRUCTIONS:
For complete claim denials when the appropriate value is not available use code '21'.

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PATIENT RELATIONSHIP TO SPONSOR (CONTINUED)**	
CODE/VALUE SPECIFICATIONS (CONTINUED)	Y	Unremarried Former Spouse divorced prior to 04/01/1985, meeting 20/20/15 criteria
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	**GROUP**
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
For complete claim denials when the appropriate value is not available use code '21'.

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT SEX

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-100	1	Yes
Non-Institutional	2-085	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code defining sex of patient. Download field from DEERS.	
CODE/VALUE SPECIFICATIONS	M	Male
	F	Female
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT SOCIAL SECURITY NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-080	1	Yes
Non-Institutional	2-065	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	Patient Social Security Number as verified through DEERS. Download field from DEERS, if value is blank on DEERS blank-fill on TED.
CODE/VALUE SPECIFICATIONS	If unknown, blank fill.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT STATUS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-270	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code indicating patient status as of the end date of care on the TED Record.	
CODE/VALUE SPECIFICATIONS	01	Discharged
	02	Transferred
	03	Discharged / transferred to skilled nursing facility (SNF)
	04	Discharged / transferred to intermediate care facility (ICF)
	05	Discharged / transferred to another type of institution for inpatient care, or referred for outpatient care to another institution
	06	Discharged / transferred to home under care of organized home health service organization
	07	Left against medical advice or discontinued care
	08	Discharged / transferred to home under care of a home IV provider
	20	Expired (or did not recover - Christian Science Patient)
	30	Still patient (remaining)
	40	Died at Home
	41	Died in a medical facility, such as a hospital, SNF, or free standing hospice
	42	Place of death unknown
	50	Discharged to Hospice - Home

NOTES AND SPECIAL INSTRUCTIONS:
N/A

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: PATIENT STATUS (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	51	Discharged to Hospice - Medical Facility
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	**GROUP**
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PATIENT ZIP CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-105	1	Yes
Non-Institutional	2-090	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	US Postal Zip Code or foreign country code for patient's legal residence at the time service was rendered and must not be the zip code of a P.O. Box.
CODE/VALUE SPECIFICATIONS	Must be a valid 5 or 9 digit zip code. If only 5 digit, left justify and blank fill to right. If foreign country, must be 3 character foreign country code, left justified and blank filled. Refer to Chapter 2, Addendum A.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PCM LOCATION DMIS-ID CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-115	1	No
Non-Institutional	2-110	1	No

PRIMARY PICTURE (FORMAT)	Four (4) alphanumeric characters.
DEFINITION	This code identifies and distinguishes MTF/Clinic enrollments from network enrollments primarily for reporting on Enrollment Based Capitation (EBC). EBC became operational on 10/01/1997. The code designations vary based on type of PRIME enrollment and begin work dates of new programs such as TRICARE Prime Remote (TPR) which has an effective date of 10/01/1999. The codes also vary based on the individual requirements of enrolling platforms used by the Managed Care Support Regions.
CODE/VALUE SPECIFICATIONS	Refer to Chapter 3, Section 1.2 for further instructions on how and when to use these codes.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **For SHCP - MTF Referred care, the referring MTF/Clinic DMIS-ID must be reported if available in the PCM Location DMIS-ID Code (see OPM Chapter 21)**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PHYSICIAN REFERRAL NUMBER**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Non-Institutional	2-270	1	Yes[1]
PRIMARY PICTURE (FORMAT)	Thirteen (13) alphanumeric characters.		
DEFINITION	The identifying number of the referring physician. This field will be made up of the NPI or PROVIDER TAXPAYER NUMBER and PROVIDER SUB-IDENTIFIER if applicable.		
CODE/VALUE SPECIFICATIONS	N / A		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required for all referred care (MTF and Civilian PCM).

DATA ELEMENT DEFINITION

ELEMENT NAME: PLACE OF SERVICE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-275	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code to indicate the location of provided health care.	
CODE/VALUE SPECIFICATIONS	11	Office
	12	Home
	21	Inpatient Hospital
	22	Outpatient Hospital
	23	Emergency Room - Hospital
	24	Ambulatory Surgical Center
	25	Birthing Center
	26	Military Treatment Facility
	31	Skilled Nursing Facility
	32	Nursing Facility
	33	Custodial Care Facility
	34	Hospice
	41	Ambulance - Land
	42	Ambulance - Air or Water
	51	Inpatient Psychiatric Facility
	52	Psychiatric Facility Partial Hospitalization
	53	Community Mental Health Center
	54	Intermediate Care Facility / Mentally Retarded
	55	Residential Substance Abuse Treatment Facility

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PLACE OF SERVICE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	56	Psychiatric Residential Treatment Center
	61	Comprehensive Inpatient Rehabilitation Facility
	62	Comprehensive Outpatient Rehabilitation Facility
	65	End Stage Renal Disease Treatment Facility
	71	State or Local public Health Clinic
	72	Rural Health Clinic
	81	Independent Laboratory
	99	Other Unlisted Facility
ALGORITHM N/A		

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	**GROUP**
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PRICING RATE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-190	1	Yes
Non-Institutional	2-325	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.
DEFINITION	The code indicating the contractor's pricing methodology used in determining the amount allowed for the service(s)/supplies.

CODE/VALUE SPECIFICATIONS	INSTITUTIONAL CODES	
	Blank	No special rate
	D	Discount rate agreement
	P	Per diem rate agreement
	H	TRICARE/CHAMPUS DRG reimbursement with SHORT STAY OUTLIER
	I	TRICARE DRG reimbursement with COST OUTLIER
	J	TRICARE DRG reimbursement with NO OUTLIER
	K	Hospital-Specific psychiatric Per Diem Rate
	L	Region-Specific psychiatric Per Diem Rate
	U	Supplemental Health Care Program Claim or Active Duty Member TPR claim Paid Outside Normal Limits
	V	Medicare Reimbursement Rate

NOTES AND SPECIAL INSTRUCTIONS:

Left justified, blank filled

[1] Code '0' for all allowed drug charges. Use Pricing Rate Code '1' (Priced Manually) for consultation procedures (906XX) for which the allowable charge is limited to that for a Limited Initial Visit, New Patient (90010).

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: PRICING RATE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	LC	TRICARE Claim-Added Procedure, CMAC Priced Laboratory Code
		NON-INSTITUTIONAL CODES
	0	Pricing not applicable (denied service/supplies and allowed drugs)
	1	Priced Manually
	2	Prevailing charge (state)
	3	Conversion Amount (state)
	4	Paid as billed
	5	Paid on negotiated rate
	A	National prevailing charge
	B	National conversion factor
	C	Ambulatory surgery-facility payment rate
	D	Discounted ambulatory surgery-facility payment rate
	E	Ambulatory surgery-paid as billed
	F	TRICARE Claimcheck-added procedure, priced manually
	G	TRICARE Claimcheck-added procedure, prevailing charge (State)
	H	TRICARE Claimcheck-added procedure, conversion factor (Contractor)
	I	TRICARE Claimcheck-added procedure, paid as billed

NOTES AND SPECIAL INSTRUCTIONS:

Left justified, blank filled

[1] Code '0' for all allowed drug charges. Use Pricing Rate Code '1' (Priced Manually) for consultation procedures (906XX) for which the allowable charge is limited to that for a Limited Initial Visit, New Patient (90010).

DATA ELEMENT DEFINITION

ELEMENT NAME: PRICING RATE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	J	TRICARE Claimcheck-added procedure, paid on negotiated rate
	K	TRICARE Claimcheck-added procedure, prevailing/conversion adjusted by MEI - primary care
	L	TRICARE Claimcheck-added procedure, prevailing/conversion adjusted by the MEI - non-primary care, total charge subject to MEI
	M	TRICARE Claimcheck-added procedure, prevailing/conversion adjusted by the MEI - non-primary care professional component only
	N	TRICARE Claimcheck-added procedure, national prevailing charge
	O	TRICARE Claimcheck-added procedure, national conversion factor
	P	TRICARE Claimcheck-added procedure, ambulatory surgery-facility payment rate
	Q	TRICARE Claimcheck-added procedure, discounted ambulatory surgery-facility payment rate
	R	TRICARE Claimcheck-added procedure, ambulatory surgery-paid as billed
	T	TRICARE Claimcheck-added procedure, allowed as billed but paid less than billed
	U	*Medicare Reimbursement Rate*

NOTES AND SPECIAL INSTRUCTIONS:

Left justified, blank filled

[1] Code '0' for all allowed drug charges. Use Pricing Rate Code '1' (Priced Manually) for consultation procedures (906XX) for which the allowable charge is limited to that for a Limited Initial Visit, New Patient (90010).

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PRICING RATE CODE (CONTINUED)**
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	**GROUP**
N / A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

Left justified, blank filled

[1] Code '0' for all allowed drug charges. Use Pricing Rate Code '1' (Priced Manually) for consultation procedures (906XX) for which the allowable charge is limited to that for a Limited Initial Visit, New Patient (90010).

DATA ELEMENT DEFINITION

ELEMENT NAME: PRINCIPAL OPERATION/NON-SURGICAL PROCEDURE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-345	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Five (5) alphanumeric characters.
DEFINITION	The code that identifies the principal procedure performed during the period covered by this TED Record as coded on the UB-92.
CODE/VALUE SPECIFICATIONS	Use the most current procedure code edition (ICD-9-CM) as directed by TMA. Must provide the most detailed code. Must be left justified and blank filled. Do not code the decimal point.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if one of the following Revenue Codes are present 36x or 72x.

DATA ELEMENT DEFINITION

ELEMENT NAME: PRINCIPAL TREATMENT DIAGNOSIS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-300	1	Yes
Non-Institutional	2-115	1	Yes

PRIMARY PICTURE (FORMAT)	Six (6) alphanumeric characters.
DEFINITION	The condition established, after study, to be the major cause for the patient to obtain medical care as coded on the claim form or otherwise indicated by the provider.
CODE/VALUE SPECIFICATIONS	Use the most current diagnosis code edition (ICD-9-CM), as directed by TMA. Must provide the most detailed code. Left justify and blank fill. Do not code the decimal point.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
For complete claim denials when the appropriate value is not available use code 7999.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROCEDURE CODE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Non-Institutional	2-160	Up to 99	Yes
PRIMARY PICTURE (FORMAT)	Five (5) alphanumeric characters.		
DEFINITION	Code indicating the procedure which describes the care received.		
CODE/VALUE SPECIFICATIONS	Refer to Physician's Current Procedure Terminology (CPT-4), or HCPCS National Level II Medicare Codes or TMA approved codes (Figure 2-E-1).		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	
NOTES AND SPECIAL INSTRUCTIONS: **N/A**			

DATA ELEMENT DEFINITION

ELEMENT NAME:	PROCEDURE CODE MODIFIER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Non-Institutional	2-165	2/Up to 99	No

PRIMARY PICTURE (FORMAT)	Two occurrences of two (2) alphanumeric characters per line item for non-institutional.
DEFINITION	Two digit code which provides the means by which the health care professional can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.
CODE/VALUE SPECIFICATIONS	Must be 20-26, 27, 32, 47, 50, 52-59, 62, 66, 73-82, 90, 99, D, E, H, N, P, R, S, X, AA, AB, AC, AD, AE, AF, AG, AH, AJ, AN, AP, AS, CC, DD, EE, EH, EJ, EM, EP, ER, ET, FP, HE, HH, HR, HT, LL, LR, LS, LT, MS, NR, NU, PH, PL, QB, QC, QD, QE, QF, QG, QH, QM, QN, QT, QU, Q5, Q6, RA, RE, RH, RP, RR, RT, SF, SH, TC, UC, UE, VP, XX, or blank.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

Can report from 0 to 2 codes. Left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters left justify and blank fill to right.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROCESSING INFORMATION**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-155	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Field containing multiple elements that describe processing related to the TED Record.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
OVERRIDE CODE	N / A
TYPE OF SUBMISSION	
CA / NAS NUMBER	
CA / NAS REASON FOR ISSUANCE	
CA / NAS EXCEPTION REASON	
SPECIAL PROCESSING CODE	
PRICING RATE CODE	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if applicable to TED Record conditions.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER GROUP NPI NUMBER**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional Non-Institutional	1-215 2-230		

PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.
DEFINITION	Reserved for future use.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER INDIVIDUAL NPI NUMBER**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Institutional Non-Institutional	1-210 2-225		
PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.		
DEFINITION	Reserved for future use.		
CODE/VALUE SPECIFICATIONS	N / A		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER NETWORK STATUS INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-230	1	Yes
Non-Institutional	2-265	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code indicating whether the provider is a network or non-network provider.	
CODE/VALUE SPECIFICATIONS	1	Network Provider
	2	Non-Network Provider
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER PARTICIPATION INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-225	1	Yes
Non-Institutional	2-260	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code indicating whether or not the provider accepted assignment of benefits for services rendered.	
CODE/VALUE SPECIFICATIONS	Y	Yes
	N	No
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER SPECIALTY**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Non-Institutional	2-255	Up to 99	Yes
PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.		
DEFINITION	Code describing the provider's specialty.		
CODE/VALUE SPECIFICATIONS	Refer to Chapter 2, Addendum C.		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER STATE OR COUNTRY CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-195	1	Yes
Non-Institutional	2-235	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Three (3) alphanumeric characters.
DEFINITION	Code assigned to identify the state or foreign country in which the care was **received**. State Code must be left justified and blank fill to right.
CODE/VALUE SPECIFICATIONS	Chapter 2, Addendum A and Addendum B.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

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DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER SUB-IDENTIFIER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-205	1	Yes
Non-Institutional	2-245	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Four (4) alphanumeric characters.
DEFINITION	Identification number that uniquely identifies multiple providers using the same Taxpayer Identification Number (TIN). Refer to provider filing instructions.
CODE/VALUE SPECIFICATIONS	Assigned as per TRICARE instructions. Must be zero-filled if there are no multiple providers within the TIN.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXPAYER NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-200	1	Yes
Non-Institutional	2-240	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	The IRS Taxpayer Identification Number (TIN) assigned to the institution / provider supplying the care.
CODE/VALUE SPECIFICATIONS	For institutions must be 9-digit Employer Identification Number (EIN). For individual providers should be the 9-digit EIN or SSN, if available. If not available, report the contractor-assigned number. (Refer to Provider File data element Provider Taxpayer Number 3-005 in the provider record for instructions). Report all nines for transportation services under Program for Persons with Disabilities and for Drug Program when the services are from a non-participating pharmacy.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER ZIP CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-220	1	Yes
Non-Institutional	2-250	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	Location of provider's business office where care is usually provided.
CODE/VALUE SPECIFICATIONS	Must be a valid 5 or 9 digit zip code. If only 5 digits, left justify and blank fill to right. If a foreign country, must be 3 character foreign country code, left justify and blank fill to right. Refer to Chapter 2, Addendum A.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

CHAPTER 2
SECTION 2.8

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (Q - S)

DATA ELEMENT DEFINITION

ELEMENT NAME:	**REASON FOR INTEREST PAYMENT**		

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-150	1	No
Non-Institutional	2-215	Up to 99	No

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric[1] characters.	
DEFINITION	This field will be used to determine the fiscal responsibility for the interest payment based on the following hierarchy.	
	A	Claims pended at Government direction that the Government has specifically directed the contractor to hold for an extended period of time. These will primarily be claims pending a Program Integrity investigation (the government is fiscally responsible for any interest).
	B	Claims requiring Government intervention (the government is fiscally responsible for any interest).
	C	Claims requiring development for potential third-party liability (The government is fiscally responsible for any interest).

NOTES AND SPECIAL INSTRUCTIONS:
[1] Left justify and blank filled to the right.

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: REASON FOR INTEREST PAYMENT (CONTINUED)		
DEFINITION (CONTINUED)	D	Claims requiring an action / interface with another prime contractor (the contractor is fiscally responsible for any interest).
	E	Claims retained by the contractor that do not fall into one of the above categories (the contractor is fiscally responsible for any interest).
CODE/VALUE SPECIFICATIONS	N / A	
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS	
SUBORDINATE	**GROUP**
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Left justify and blank filled to the right.**

DATA ELEMENT DEFINITION

ELEMENT NAME: RECORD TYPE INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-001	1	Yes[1]
Non-Institutional	2-001	1	Yes[1]

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code to indicate the type of record.	
CODE/VALUE SPECIFICATIONS	1	Institutional
	2	Non-Institutional
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Refer to the Chapter 2, Section 1.2, paragraph 1.0. for further instructions.**

DATA ELEMENT DEFINITION

ELEMENT NAME: REGION INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-112	1	Yes
Non-Institutional	2-303	Up to 99	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric character.	
DEFINITION	Region Indicator is the region of the Managed Care Support Contractor responsible for the care provided.	
CODE/VALUE SPECIFICATIONS	Region 1	Northeast
	Region 2	Mid-Atlantic
	Region 3	Southeast
	Region 4	Gulfsouth
	Region 5	Heartland
	Region 6	Southwest
	Region 7	Central
	Region 8	Central
	Region 9	Southern California
	Region 10	Golden Gate
	Region 11	Northwest
	Region 12	Hawaii/Alaska
	Region 13	Europe
	Region 14	Pacific
	Region 15	Latin America & Canada (including the Caribbean Basin)
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
Left justify and blank fill.

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: REVENUE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-385	Up to 999	Yes[1]

PRIMARY PICTURE (FORMAT)	Four (4) alphanumeric characters.
DEFINITION	Code which identifies revenue categories associated with the type of service rendered. Like revenue codes should be summarized to one occurrence for reporting on the TED Record. Room and board revenue codes can be summarized if the code and rate are the same. Denied revenue codes must be reported on separate occurrence(s) within the TED Record.
CODE/VALUE SPECIFICATIONS	Use UB-92 revenue codes.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **All Revenue codes must be reported for each TED Record.**

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Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: SECONDARY OPERATION/NON-SURGICAL PROCEDURE CODES

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-350 -- 1-370	5	Yes[1]

PRIMARY PICTURE (FORMAT)	Five (5) alphanumeric characters.
DEFINITION	Codes identifying the procedures, other than the principal procedure, performed during the period covered by the TED Record.
CODE/VALUE SPECIFICATIONS	Refer to International Classification of Diseases - Clinical Modification, Edition 9, Volume 3, for valid ICD-9-CM Operation / Non-surgical codes. Must code the most detailed procedure. Must be left justified and blank filled.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required if available.

DATA ELEMENT DEFINITION

ELEMENT NAME: SECONDARY TREATMENT DIAGNOSIS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-305 -- 1-340	8	Yes[1]
Non-Institutional	2-120 -- 2-135	4	Yes[1]

PRIMARY PICTURE (FORMAT)	Six (6) alphanumeric characters.
DEFINITION	Code corresponding to additional conditions that co-exist at the time of admission or during the treatment encounter.
CODE/VALUE SPECIFICATIONS	Use the most current diagnoses edition (ICD-9-CM) as directed by TMA. Must code the most detailed procedure. Code must be left justified and blank filled.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Required if available.**

DATA ELEMENT DEFINITION

ELEMENT NAME: SEQUENCE NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-025	1	Yes
Non-Institutional	2-025	1	Yes

PRIMARY PICTURE (FORMAT)	Seven (7) alphanumeric characters.
DEFINITION	A sequential number assigned by the contractor to identify the individual TED Record. Once assigned, the sequence number cannot be re-used with the same Filing Date and Filing State/Country.
CODE/VALUE SPECIFICATIONS	The sequential identifying number assigned by the contractor.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	INTERNAL CONTROL NUMBER

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: SOURCE OF ADMISSION

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-260	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code indicating admission referral source.	
CODE/VALUE SPECIFICATIONS	**SOURCE OF ADMISSION CODES**	
	1 Physician Referral	The patient was admitted to this facility upon the recommendation of his or her personal physician.
	2 Clinic Referral	The patient was admitted to this facility upon recommendation of this facility's clinic physician.
	3 HMO Referral	The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.
	4 Transfer from a Hospital	The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.
	5 Transfer from a Skilled Nursing Facility	The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.
	6 Transfer from another Health Care Facility	The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility.
	7 Emergency	The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.

NOTES AND SPECIAL INSTRUCTIONS:

For complete claim denials when the appropriate value is not available use code '9'.

[1] Use this coding structure when the TYPE OF ADMISSION = '4' (NEWBORN).

DATA ELEMENT DEFINITION

ELEMENT NAME: SOURCE OF ADMISSION (CONTINUED)			
CODE/VALUE SPECIFICATIONS (CONTINUED)	8	Court/Law Enforcement	The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
	9	Information Not Available	The means by which the patient was admitted to this hospital is not known.
		CODE STRUCTURE FOR NEWBORN[1]	
	1	Normal Delivery	A baby delivered without complications.
	2	Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
	3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
	4	Extramural Birth	A newborn born in a non-sterile environment.
ALGORITHM	N/A		

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	**GROUP**
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

For complete claim denials when the appropriate value is not available use code '9'.

[1] Use this coding structure when the TYPE OF ADMISSION = '4' (NEWBORN).

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-185	4	Yes[1]
Non-Institutional	2-305	4/Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Four occurrences of two (2) alphanumeric characters per line items for non-institutional.	
DEFINITION	Code indicating care that requires special processing.	
CODE/VALUE SPECIFICATIONS	0	Hospice Non-Affiliated Provider
	1	Medicaid
	3	Allogeneic Bone Marrow Recipient (Wilford Hall referred only)
	4	Allogeneic Bone Marrow Donor (Wilford Hall referred only)
	5	Liver Transplant (for care before 03/01/1997, or ((> 02/19/1998 and < 09/01/1999))
	6	Home Health Care (Non-Institutional Only)
	7	Heart Transplant
	10	Active Duty Cost-Share Ambulatory Surgery Taken From Professional Claim[3]
	11	Hospice
	12	Capitated Arrangements

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters. Left justify and blank fill.

[2] This code is to be used for services provided in a designated STS Facility on or after 03/01/1997.

[3] Not-At-Risk Payment By Contractor.

[4] Part of the claim can be processed as at-risk and part as not-at-risk.

[5] Whenever special processing code = 'E', (grandfathered HHC claims) is coded, then special processing code 'CM' must also appear.

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	14	Bone Marrow Transplants - TMA Approved
	16	Ambulatory Surgery Facility Charge
	A	Partnership Program (Internal Providers with signed agreements)
	E[5]	Grandfathered from Home Health Care/Case Management (HHC/CM) Demonstration (After 03/15/1999, Grandfathered into the Individual Case Management Program)
	Q	Active Duty Delayed Deductible
	R	Medicare/TRICARE Dual Entitlement
	S	Resource Sharing External
	T	Medicare/TRICARE Dual Entitlement (normal COB processing)
	U	BRAC Medicare Pharmacy (Section 702) claim (Terminated 04/01/2001)
	V	At-risk payment by claims processor
	W[3]	Not-At-Risk payment by at-risk claims processor

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters. Left justify and blank fill.

[2] This code is to be used for services provided in a designated STS Facility on or after 03/01/1997.

[3] Not-At-Risk Payment By Contractor.

[4] Part of the claim can be processed as at-risk and part as not-at-risk.

[5] Whenever special processing code = 'E', (grandfathered HHC claims) is coded, then special processing code 'CM' must also appear.

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	X	Partial hospitalization - provider not contracted with or employed by the partial hospitalization program billing for psychotherapy services in a partial hospitalization program
	Y	Heart-Lung Transplant
	Z	Kidney Transplant
	AB[3]	Abused Dependent of Discharged or Dismissed Member, Not-At-Risk Payment of Contractor (Effective 07/28/1999)
	AD[3]	Foreign Active Duty Claims (Effective 06/30/1996)
	AN[3]	Supplemental Health Care Program - Non-MTF-Referral Care (Effective 10/01/1999 through 06/01/2001)
	AR[3]	Supplemental Health Care Program - Referred Care[3] (Effective 10/01/1999 through 06/01/2001)
	BD	Bosnia Deductible (Effective 12/08/1995)
	CA	Civil Action Payment (Effective 07/01/1999)
	CE[3]	Supplemental Health Care Program - Comprehensive Clinical Evaluation Program (Effective 10/01/1999)

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters. Left justify and blank fill.

[2] This code is to be used for services provided in a designated STS Facility on or after 03/01/1997.

[3] Not-At-Risk Payment By Contractor.

[4] Part of the claim can be processed as at-risk and part as not-at-risk.

[5] Whenever special processing code = 'E', (grandfathered HHC claims) is coded, then special processing code 'CM' must also appear.

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	CM[4]	Individual Case Management Program (ICMP) Claims (Effective 03/15/1999)
	EU	Emergency Services Rendered by an Unauthorized Provider (Effective 06/01/1999)
	FF[3]	TRICARE for Life (First Payor) (Effective 10/01/2001)
	FS[3]	TRICARE for Life (Second Payor) (Effective 10/01/2001)
	GF	TRICARE Eligible Family Member Residing with a TPR Eligible Active Duty Service Member (Effective 10/30/2000)
	GU[3]	Active Duty Service Member enrolled in TRICARE Prime Remote (Effective 10/01/1999)
	KO	Allied Forces - Kosovo (Effective 06/01/1999)
	MH	Mental Health Active Duty Cost-Share
	MS[3]	TRICARE - Senior Prime (Network) (Effective 01/01/1998 through 12/31/2001)
	MN[3]	TRICARE - Senior Prime (Non-Network) (Effective 01/01/1998 through 12/31/2001)

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters. Left justify and blank fill.

[2] This code is to be used for services provided in a designated STS Facility on or after 03/01/1997.

[3] Not-At-Risk Payment By Contractor.

[4] Part of the claim can be processed as at-risk and part as not-at-risk.

[5] Whenever special processing code = 'E', (grandfathered HHC claims) is coded, then special processing code 'CM' must also appear.

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DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	PD[3]	Pharmacy Redesign Pilot Program (Effective 07/01/2000 through 04/01/2001)
	PF	Program for Persons with Disability
	PO	TRICARE Prime - Point of Service
	RI	Resource Sharing Internal
	SC[3]	Supplemental Health Care Program - Non-TRICARE Eligible (Effective 10/01/1999)
	SE[3]	Supplemental Health Care Program - TRICARE Eligible (Effective 10/01/1999)
	SM[3]	Supplemental Health Care Program - Emergency (Effective 10/01/1999)
	SN[3]	TRICARE Senior Supplement (Non-Network) (Effective 04/01/1999)
	SP[4]	Special/Emergent Care (Effective 06/01/1999)
	SS[3]	TRICARE Senior Supplement (Network) (Effective 04/01/1999)
	ST[2]	Specialized Treatment
	WR	Mental Health Wraparound Demonstration
ALGORITHM	N/A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters. Left justify and blank fill.

[2] This code is to be used for services provided in a designated STS Facility on or after 03/01/1997.

[3] Not-At-Risk Payment By Contractor.

[4] Part of the claim can be processed as at-risk and part as not-at-risk.

[5] Whenever special processing code = 'E', (grandfathered HHC claims) is coded, then special processing code 'CM' must also appear.

DATA ELEMENT DEFINITION

ELEMENT NAME: SPECIAL PROCESSING CODE (CONTINUED)

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

1. **Required if TED Record processing is applicable to special processing conditions. Can report from 0 to 4 codes, left justify and blank fill. Do not duplicate. Each occurrence consists of two (2) characters. Left justify and blank fill.**
2. **This code is to be used for services provided in a designated STS Facility on or after 03/01/1997.**
3. **Not-At-Risk Payment By Contractor.**
4. **Part of the claim can be processed as at-risk and part as not-at-risk.**
5. **Whenever special processing code = 'E', (grandfathered HHC claims) is coded, then special processing code 'CM' must also appear.**

DATA ELEMENT DEFINITION

ELEMENT NAME: SPONSOR BRANCH OF SERVICE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-060	1	Yes[1]
Non-Institutional	2-055	1	Yes[1]

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Sponsor's Uniformed Service Branch or Organization. Download field from DEERS.	
CODE/VALUE SPECIFICATIONS	A	Army
	C	CHAMPVA (Denied CHAMPVA Claims Only After 01/01/1996)
	E	Public Health Service
	F	Air Force
	I	NOAA
	M	Marines
	N	Navy
	P	Coast Guard
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **If unavailable from DEERS, report branch of service from the claim or treatment encounter data. 'X' and "Z" are not allowed. For NATO claims, the code/value that reflects the sponsoring military service of the NATO member shall be used and "Sponsor Status" shall be reported as "T".**

DATA ELEMENT DEFINITION

ELEMENT NAME: SPONSOR PAY GRADE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-055	1	Yes[1]
Non-Institutional	2-290	Up to 99	Yes[1]

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters. Download field from DEERS.	
DEFINITION	Sponsor's pay grade.	
CODE/VALUE SPECIFICATIONS	01 - 09	Enlisted (El - E9)
	11 - 15	Warrant Officer (W1 - W5)
	19	Academy or Navy OCS Students
	20	Unknown Officer
	21 - 31	Officer (O1 - O11)
	41 - 58	GS1 - GS18
	90	Unknown (including NATO)
	95	Not Applicable
	99	Other
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **For TED Records reporting services under Program for Persons with Disabilities, Sponsor Pay Grade must be one of the following 01-09, 11-15, or 21-31. For complete claim denials when the appropriate value is not available use code 90.**

DATA ELEMENT DEFINITION

ELEMENT NAME: SPONSOR SOCIAL SECURITY NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-050	1	Yes
Non-Institutional	2-050	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	Sponsor Social Security number as verified through DEERS. Download field from DEERS.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
Must be numeric or blank.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**SPONSOR STATUS**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Institutional	1-065	1	Yes[1]
Non-Institutional	2-285	Up to 99	Yes[1]
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Code indicating current status of the sponsor at the time the care was rendered, as verified through DEERS. Download field from DEERS.		
CODE/VALUE SPECIFICATIONS		**ACTIVE DUTY**	
	A	Active Duty	
	B	Recalled to Active Duty	
	J	Academy Student / Navy OCS	
	N	National Guard	
	Q	Prisoner / Appellate	
	T	Foreign Military (NATO)	
	V	Reserve	
		RETIRED	
	D	100% Disabled	
	F	Former Member	
	I	Permanently Disabled	
	O	Temporarily Disabled	
	R	Retired	
	W	Title III Retiree	
		DECEASED	
	K	Deceased	
		OTHER	
	C	Civilian	

NOTES AND SPECIAL INSTRUCTIONS:

[1] NATO TED Records must be reported using code 'T' Foreign Military even though DEERs includes them in code 'X' other. For complete claim denials when the appropriate value is not available use code Z.

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**SPONSOR STATUS (CONTINUED)**	
CODE/VALUE SPECIFICATIONS (CONTINUED)	H	Medal of Honor
	P	TAMP Designee
	X	Other
	Z	Unknown
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	**GROUP**
N / A	BENEFICIARY CATEGORY

NOTES AND SPECIAL INSTRUCTIONS:

[1] **NATO TED Records must be reported using code 'T' Foreign Military even though DEERs includes them in code 'X' other. For complete claim denials when the appropriate value is not available use code Z.**

CHAPTER 2
SECTION 2.9

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (T - Z)

DATA ELEMENT DEFINITION

ELEMENT NAME: TED RECORD INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-005	1	Yes
Non-Institutional	2-005	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Field containing multiple elements that uniquely identify each TRICARE Encounter Data Record.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
INTERNAL CONTROL NUMBER TIME STAMP ADJUSTMENT KEY	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: TIME STAMP

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-030	1	Yes[1]
Non-Institutional	2-030	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Six (6) alphanumeric characters.
DEFINITION	Unique system time assigned by the claims processor's computer system when issuing an initial TED Record record.
CODE/VALUE SPECIFICATIONS	Issued in MMSSHH (Minutes, Seconds, Hundredths)
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	TED RECORD INDICATOR

NOTES AND SPECIAL INSTRUCTIONS:

[1] **System Time that is issued only on initial TED Record record. Used as part of the TRICARE Encounter Data (TED) Record Indicator field for unique key definition. TYPE OF SUBMISSION A, C, and F TED Records should be submitted using the same Time value as the initial TED Record. An initial TYPE OF SUBMISSION B TED Record should be submitted with a unique Time value. Any subsequent TYPE OF SUBMISSION B records for the same TED should be submitted with the same Time value as the initial. A TYPE OF SUBMISSION E TED Record, for which there has never been a TYPE OF SUBMISSION B TED Record submitted, should contain a unique Time value. A TYPE OF SUBMISSION E TED Record for which there has been an initial TYPE OF SUBMISSION B record submitted should use the same Time value as the initial record.**

DATA ELEMENT DEFINITION

ELEMENT NAME: TOTAL CHARGE BY REVENUE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-395	Up to 999	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) signed numeric digits including two (2) decimal places.
DEFINITION	Amount billed for this revenue code.
CODE/VALUE SPECIFICATIONS	Must be equal to or less than 999,999.99 unless Revenue Code 001 which must be equal to or less than 9,999,999.99.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**TOTAL OCCURRENCE/LINE ITEM NUMBER**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-375	1	Yes
Non-Institutional	2-140	1	Yes

PRIMARY PICTURE (FORMAT)	Three (3) signed numeric digits.
DEFINITION	**Institutional:** The number of sets of revenue codes and related data elements that occur on the record. **Non-Institutional:** The number of sets of procedure codes and related utilization data elements that occur on the record.
CODE/VALUE SPECIFICATIONS	**Institutional:** Must be greater than 0 and not more than 999. **Non-Institutional:** Must be greater than 0 and not more than 99[1].
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **This is a 3 digit field to allow for growth. However, the TED value for this field cannot exceed 99.**

DATA ELEMENT DEFINITION

ELEMENT NAME: TYPE OF ADMISSION

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-255	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	A code indicating the type of this admission.	
CODE/VALUE SPECIFICATIONS	1 Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
	2 Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
	3 Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
	4 Newborn	Use of this code necessitates the use of special SOURCE OF ADMISSION codes (1 through 4). Must not be used for the mother.
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	TYPE OF BILL

NOTES AND SPECIAL INSTRUCTIONS:
For complete claim denials when the appropriate value is not available use code 3.

DATA ELEMENT DEFINITION

ELEMENT NAME: TYPE OF BILL

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-245	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Field that contains multiple elements to define details of a patient's stay in the institution.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
FREQUENCY CODE TYPE OF ADMISSION	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: TYPE OF INSTITUTION

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-235	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters required.
DEFINITION	A code describing the type of institution for institutional providers.
CODE/VALUE SPECIFICATIONS	Refer to Chapter 2, Addendum D.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**TYPE OF SERVICE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Non-Institutional	2-280	Up to 99	Yes
PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.		
DEFINITION	Code to indicate the type of service provided.		
CODE/VALUE SPECIFICATIONS	**TYPE OF SERVICE - FIRST POSITION VALUES**		
	A	Ambulatory surgery cost-shared as inpatient (Active Duty family members only)	
	C	Air Force CAM primary/ preventive outpatient care (Effective prior to 04/1997)	
	I	Inpatient	
	K	Emergency Room Admission cost-shared as inpatient.	
	M	Outpatient maternity care cost-shared as inpatient	
	N	Outpatient cost-shared as inpatient	
	O	Outpatient, excluding M, P, or N	
	P[1]	Outpatient partial psychiatric hospitalization care cost-shared as inpatient	
	TYPE OF SERVICE CODES - SECOND POSITION VALUES		
	1	Medical Care	
	2	Surgery	
	3	Consultation	
	4	Diagnostic/Therapeutic X-Ray	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **The first position values of TYPE OF SERVICE is 'P', the second position must be 'H'.**

[2] **If the second position values TYPE OF SERVICE Code 'C' is used on TED Records for other than Active Duty family members. Do not report in conjunction with first position Code 'A'.**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: TYPE OF SERVICE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	5	Diagnostic Laboratory
	6	Radiation Therapy
	7	Anesthesia
	8	Assistance at Surgery
	9	Other Medical Services & Supplies
	A	DME Rental / Purchase
	B	Drugs
	C[2]	Ambulatory Surgery
	D	Hospice
	E	Second Opinion on Elective Surgery
	F	Maternity
	G	Dental
	H	Mental Health Care
	I	Ambulance
	J	Program for Persons with Disabilities
	K	Physical / Occupational Therapy
	L	Speech Therapy
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **The first position values of TYPE OF SERVICE is 'P', the second position must be 'H'.**

[2] **If the second position values TYPE OF SERVICE Code 'C' is used on TED Records for other than Active Duty family members. Do not report in conjunction with first position Code 'A'.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**TYPE OF SUBMISSION**	

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-165	1	Yes[1]
Non-Institutional	2-100	1	Yes[1]

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code indicating the TED Record submission type.	
CODE/VALUE SPECIFICATIONS	A	Adjustment to TED Record data
	B[2]	Adjustment to non-TED Record (HCSR) data
	C	Complete cancellation of TED Record data
	D	Complete contractor denial initial TED Record submission
	E[2]	Complete cancellation of non-TED Record (HCSR) data
	I	Initial TED Record submission
	O	Zero payment TED Record due to 100% OHI
	R	Resubmission of an initial TED Record (TYPE OF SUBMISSION was 'I') that was rejected due to errors
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	PROCESSING INFORMATION

NOTES AND SPECIAL INSTRUCTIONS:

[1] Non-TED Record codes 'B' and 'E' are to be used when reporting a cancellation or adjustment for a claim that was initially processed using HCSR Record format. Refer to Chapter 2, Section 1.2 for further instructions.

[2] Type Of Submission 'B' and 'E' are not valid if Beginning Date of Care is on or after 10/01/2006.

DATA ELEMENT DEFINITION

ELEMENT NAME: UNITS OF SERVICE BY REVENUE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-390	Up to 999	Yes[1]

PRIMARY PICTURE (FORMAT)	Seven (7) signed numeric digits.
DEFINITION	The number of services rendered or number of days, by revenue category.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **All revenue codes must be reported for each TED Record. For complete claim denials when the appropriate value is not available use code 1.**

CHAPTER 2
SECTION 2.10

DATA REQUIREMENTS - PROVIDER RECORD DATA

DATA ELEMENT DEFINITION

ELEMENT NAME:	**AHA MULTI-HOSPITAL SYSTEM CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-105	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Four (4) alphanumeric characters.
DEFINITION	Code assigned by the American Hospital Association to identify multi-hospital systems.
CODE/VALUE SPECIFICATIONS	Must be blank if provider is not an institution.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Not required if provider is not an institution or part of a multi-hospital system. Otherwise, required if available.**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: AMERICAN HOSPITAL ASSOCIATION ID NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-100	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	The identification number assigned to the institution by the American Hospital Association
CODE/VALUE SPECIFICATIONS	Must be blank if provider is not an institution.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required if available.

DATA ELEMENT DEFINITION

ELEMENT NAME: AREA WAGE INDEX

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-140	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Five (5) numeric digits, including four (4) decimal places.
DEFINITION	Adjustment factored to the labor-related portion of the Adjusted Standardized Amount (ASA) to account for the differences in wages among geographic areas, based on the hospital's physical address, not billing address.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Zero fill for all non-institutional providers and all DRG-exempt institutional facilities not reimbursed using an Area Wage Index.**

DATA ELEMENT DEFINITION

ELEMENT NAME: AREA WAGE INDEX EFFECTIVE DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-145	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	Date the Area Wage Index or a change to the index became effective.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] Zero fill if not applicable.

DATA ELEMENT DEFINITION

ELEMENT NAME: CONTRACTOR NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-020	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Identification code for the contractor. Used to identify each contractor submitting Provider File Records.	
CODE/VALUE SPECIFICATIONS	TMA assigned contractor number.	
	03	TRICARE - Region 3/4
	06	TRICARE - Region 6
	07	TRICARE - Central Region (Regions 7/8)
	11	TRICARE - Region 11
	25	TRICARE - Region 2/5
	26	TRICARE - Region 1
	45	Used to Update Provider File - for Foreign Providers
	60	TRICARE - Region 9/10/12
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: DRG EXEMPT/NON-EXEMPT INDICATOR

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-150	1	Yes1

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Indicates whether the institutional provider is exempted from the TRICARE/CHAMPUS DRG-based payment system.	
CODE/VALUE SPECIFICATIONS	C	DRG Non-exempt/Contracted Reimbursement Arrangement
	E	DRG Exempt
	N	DRG Non-exempt
	Blank	Not applicable
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] Report blank for all non-institutional providers.

DATA ELEMENT DEFINITION

ELEMENT NAME: DRG EXEMPT/NON-EXEMPT INDICATOR EFFECTIVE DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-155	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	Date the exempt/non-exempt status of the institutional provider became effective or a status change became effective.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] Zero fill for all non-institutional providers.

DATA ELEMENT DEFINITION

ELEMENT NAME: IDME RATIO

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-130	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Five (5) numeric digits, including four (4) decimal places.
DEFINITION	The ratio used on a hospital-specific basis to standardize the charges for the cost effects of Indirect Medical Education factors for teaching hospitals.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Zero fill for all non-institutional providers and all DRG-exempt institutional facilities not reimbursed using an IDME Ratio.**

DATA ELEMENT DEFINITION

ELEMENT NAME: IDME RATIO EFFECTIVE DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-135	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.	
DEFINITION	Date the IDME ratio or a change to the IDME ratio became effective.	
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year
	MM	2 digit calendar month
CODE/VALUE SPECIFICATIONS	DD	2 digit calendar day
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Zero fill for all non-institutional providers and DRG-exempt institutional providers.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**INSTITUTIONAL OR NON-INSTITUTIONAL INDICATOR**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-030	1	Yes[1]
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Code used to identify a provider as an institution or non-institution.		
CODE/VALUE SPECIFICATIONS	I	Institution[1]	
	N	Non-Institution	
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **An institution is any facility having the capability to retain a patient overnight, excluding Free Standing Birthing Centers and Free Standing Ambulatory Surgery Centers. In addition, if the institution provides professional services related to DRG claims and/or has clinics affiliated with it (using the same TIN), it must be reported as a 'Non-Institutional' provider, with indicator 'N'. Refer to the instructions under PROVIDER SUBIDENTIFIER for reporting.**

DATA ELEMENT DEFINITION

ELEMENT NAME: MEDICARE NUMBER

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-110	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters.
DEFINITION	Number assigned to an institution by Medicare.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Report blank for non-institutional and institutional providers not Medicare-approved or in a foreign country.**

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER ACCEPTANCE DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-115	1	Yes

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.
DEFINITION	Date a provider met criteria to provide services. If the provider was never qualified to provide services zero fill.
CODE/VALUE SPECIFICATIONS	Must be valid date YYYYMMDD. Should be latest date of acceptance.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

When submitting a provider record for a provider who has never met the criteria to provide services, the Provider Acceptance and Termination dates must be zero filled.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER ADDRESS**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-040	1	Yes

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Actual physical location of the provider's place of business.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
PROVIDER STREET ADDRESS PROVIDER CITY PROVIDER STATE OR COUNTRY CODE PROVIDER ZIP CODE	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER BILLING ADDRESS

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-065	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Group
DEFINITION	Billing mailing address of the TRICARE Provider.
CODE/VALUE SPECIFICATIONS	Left justified and blank filled. Blank fill if not required.[1]
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
PROVIDER BILLING STREET ADDRESS PROVIDER BILLING CITY PROVIDER BILLING STATE OR COUNTRY CODE PROVIDER BILLING ZIP CODE	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] Required only if different than Provider Address.

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER BILLING CITY

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-075	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eighteen (18) alphanumeric characters.
DEFINITION	City name for mailing address of TRICARE provider.
CODE/VALUE SPECIFICATIONS	Left justified and blank filled. Blank fill if not required.[1]
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	PROVIDER BILLING ADDRESS

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required only if different than Provider Address.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER BILLING STATE OR COUNTRY CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-080	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Three (3) alphanumeric characters.
DEFINITION	State or country of provider's mailing address. State Code must be left justified and blank fill to right.
CODE/VALUE SPECIFICATIONS	Refer to Chapter 2, Addendum A. Blank fill if not required.[1]
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	PROVIDER BILLING ADDRESS

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required only when different than Provider Address.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER BILLING STREET ADDRESS**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-070	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Thirty (30) alphanumeric characters.
DEFINITION	Billing mailing address of the provider. Can be street, P.O. Box or R. Route. Standard U.S. Postal Service abbreviations must be used.
CODE/VALUE SPECIFICATIONS	Left justified and blank filled. Blank fill if not required.[1]
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	PROVIDER BILLING ADDRESS

NOTES AND SPECIAL INSTRUCTIONS:
[1] Required only if different than Provider Address.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER BILLING ZIP CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-085	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	Zip code for provider mailing address.
CODE/VALUE SPECIFICATIONS	Must be valid zip code or blank. Must be blank if not required.[1]
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	PROVIDER BILLING ADDRESS

NOTES AND SPECIAL INSTRUCTIONS:

[1] First five digits are required if different from Provider Address.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER CITY**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-050	1	Yes
PRIMARY PICTURE (FORMAT)	Eighteen (18) alphanumeric characters.		
DEFINITION	City in which the provider of medical care is located.		
CODE/VALUE SPECIFICATIONS	Must be left justified and blank filled.		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		PROVIDER ADDRESS	
NOTES AND SPECIAL INSTRUCTIONS: **N/A**			

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER CONTRACT AFFILIATION CODE**	

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-025	1	Yes

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric.	
DEFINITION	Code indicates whether the provider is under contract with the contractor	
CODE/VALUE SPECIFICATIONS	0	Not applicable
	1	Contracted[1]
	2	Not Contracted[1]
	3	Contracted / Not Contracted[1]
	4	Active Duty - TPR
	5	Non-Certified Providers (Does not Include Sanction / Suspended Providers)
ALGORITHM	N / A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Codes '1', '2' and '3' apply only to at-risk contractors and subcontractors. Report '0' if not an at-risk contractor. All codes are irrespective of any Partnership agreements.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER MAJOR SPECIALTY/TYPE OF INSTITUTION**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-090	1	Yes

PRIMARY PICTURE (FORMAT)	Ten (10) alphanumeric characters.
DEFINITION	Code describing a provider's major specialty for non-institutional TEDs or a code describing the type of institution for institutional TEDs. Type of Institution must be left justified and blank filled to the right.
CODE/VALUE SPECIFICATIONS	Refer to Chapter 2, Addendum C for non-institutional provider specialty codes. Refer to Chapter 2, Addendum D for type of institution codes for Institutional TEDs.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER NAME**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-035	1	Yes

PRIMARY PICTURE (FORMAT)	Forty (40) alphanumeric characters.
DEFINITION	Name of provider.
CODE/VALUE SPECIFICATIONS	Must be left justified and blank filled. If this field is a person's name, it should be in the form of last name, first name, middle initial (each name should be separated by a comma with no space between the name). Do not use articles such as 'the,' 'A', 'An', etc. Use standard abbreviations such as 'St.' for Saint, 'Comm' for community, 'Hosp' for hospital, etc.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER STATE OR COUNTRY CODE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-055	1	Yes
PRIMARY PICTURE (FORMAT)	Three (3) alphanumeric characters.		
DEFINITION	Code assigned to identify the state or foreign country in which the provider is physically located. State codes will be left justified and blank filled to the right.		
CODE/VALUE SPECIFICATIONS	Reference Chapter 2, Addendum A and Addendum B.		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER STREET ADDRESS**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-045	1	Yes
PRIMARY PICTURE (FORMAT)	Thirty (30) alphanumeric characters.		
DEFINITION	Street address of an TMA provider's location. Standard U.S. Postal Service abbreviations must be used. P. O. Box may be used only for providers whose specialty code '05' (anesthesiology) or '30' (radiology) or '22' (pathology).		
CODE/VALUE SPECIFICATIONS	Must be left justified and blank filled.		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		PROVIDER ADDRESS	
NOTES AND SPECIAL INSTRUCTIONS: **N/A**			

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER SUB-IDENTIFIER**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-010	1	Yes

PRIMARY PICTURE (FORMAT)	Four (4) alphanumeric characters.
DEFINITION	Identification number that uniquely identifies multiple providers using the same Taxpayer Identification Number (TIN).
CODE/VALUE SPECIFICATIONS	Must be blank-filled if there are no multiple providers within TIN and zip code. For non-institutional providers including institutions that render non-institutional care (e.g., outpatient), no two Provider Subidentifiers may be the same within the same TIN and zip code. For clinics, subidentifier is assigned with an alpha character in first position followed by three numeric, sequentially assigned numbers. When the clinic itself is submitted (specialty code 70), the sequential number must always be 001. Individual providers within would then begin with 002 and so on, all having the same alpha character in the first position as on the clinic record. All other non-institutional providers must use numerics in all four characters of the subidentifier. Refer to the following examples.
	Institutional provider subidentifiers are to be numeric and sequentially assigned within TIN. However, follow the requirements as shown in example below for reporting institutional providers as non-institutional for TEDs.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

PROVIDER SUBIDENTIFIER EXAMPLE 1

Example: City Wide Clinic with a TIN of 123456789 has three locations in an area. They would be submitted to TMA in the following format:

TIN	ZIP CODE	SUB ID	NAME	SPEC
123456789	12345	A001	City Wide Clinic 1	70
123456789	12345	A002	Doctor Jones	04
123456789	12345	A003	Doctor Smith	20
123456789	12345	A004	Doctor Brown	28
123456789	12345	A005	Doctor Doe	34
123456789	12345	B001	City Wide Clinic 2	70
123456789	12345	B002	Doctor Watson	01
123456789	12345	B003	Doctor Allen	28
123456789	54321	A001	City Wide Clinic 3	70
123456789	54321	A002	Doctor Peterson	02
123456789	54321	A003	Doctor Adams	05

PROVIDER SUBIDENTIFIER EXAMPLE 2

Example: Township Hospital with a Taxpayer Identification Number (TIN) of 987654321 has two affiliated clinics in its area. In addition, Township Hospital provides outpatient services (e.g., emergency room, etc.). These provider records should be reported to TMA in the following manner:

TIN	ZIP CODE	I/N-I IND	SID	NAME	SPEC
987654321	67890	N	0000	Township Hospital	99
987654321	67890	N	A001	Township Ear Nose & Throat Clinic	70
987654321	67890	N	A002	Dr. Jones	01
987654321	67890	N	A003	Dr. Smith	20
987654321	69116	N	A001	Township Surgeons Group	70
987654321	69116	N	A002	Dr. Cutter	02
987654321	69116	N	A003	Dr. Suture	33

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER TAXPAYER NUMBER**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-005	1	Yes

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	The IRS Taxpayer Identification Number assigned to the provider supplying the care.
CODE/VALUE SPECIFICATIONS	For institutions must be 9-digit Employer Identification Number (EIN). For individual providers must be 9-digit EIN or SSN if EIN is not applicable. If not available, follow reporting requirements listed on next page.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

Provider Taxpayer Number Reporting Requirements

1. The contractor who is responsible for certifying the provider shall assign an Assigned Provider Number (APN) as outlined below when the actual Taxpayer Identification Number (TIN) of a provider is not available. The use of a contractor-assigned APN is restricted to the following situations:

A. The provider is located in a foreign country and does not have a TIN. If a foreign provider has a TIN, it is to be used. Otherwise, an APN is used regardless of whether the claim is to be paid or denied.

B. The provider does not meet TRICARE certification requirements or the contractor does not have substantial evidence that the provider meets the TRICARE certification requirements.

C. The contractor has substantial evidence that the provider meets the TRICARE certification requirements. In this case, the payment must be made to the beneficiary.

2. When neither the EIN nor the SSN is available for the provider and the provider is located in your contract area.

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TAXPAYER NUMBER (CONTINUED)

Note: Claims for care rendered by an institutional provider located in the United States must be processed with a valid EIN. Contractor-assigned provider numbers will not be allowed.

A. If the provider is located in a foreign country, the field is coded in the following manner.

Position 1 and 2 - The two character alpha abbreviation of the country in which the provider or institution is located (Chapter 2, Addendum A).

Position 3 thru 9 - A seven-digit sequential contractor assigned number. These numbers are to be permanently assigned to the provider.

Example: The first provider from Mexico will be coded MX0000001.

B. If the provider is not an institutional provider and is located in the United States, the field is coded in the following manner.

Position 1 and 2 - The two character numeric abbreviation of the state in which the provider or facility is located (Chapter 2, Addendum B).

Position 3 thru 9 - A seven-digit sequential contractor assigned number.

Example: The first provider from Maryland would be coded 24000001. Refer to instruction below, for exception.

C. For Program for Persons with Disabilities, if the TED is for transportation via a privately owned vehicle (POV), do not assign an APN or submit a provider record.

D. For the Drug Program when the services are from a non-participating pharmacy, do not assign an APN or submit a provider record.

3. If it is necessary to assign a number for a provider that is outside of your contract area, the number is assigned following all the above rules except the third high order digit must be an "A".

Example: If a beneficiary, whose care when traveling outside of your area is your responsibility, received care in Mexico, it will be coded MXA000001.

Note: These numbers, once assigned, will not be reassigned to another provider. Upon receipt of a valid EIN or SSN, inactivate the APN provider record and submit an'ADD' transaction for the actual TIN. After the TIN record is added, subsequent adjustments to the TEDs previously reported using an APN shall be reported with the current TIN and provider information.

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER TAXPAYER NUMBER IDENTIFIER**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-015	1	Yes
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric digit.		
DEFINITION	Code to identify the Provider Taxpayer Identification Number as being an EIN or SSN or contractor assigned.		
CODE/VALUE SPECIFICATIONS	E	Indicates "EIN"	
	S	Indicates "SSN" (valid for non-institutional only)	
	A	Assigned by contractor (valid only for non-institutional providers when no payment is made to the provider, and providers from foreign countries without a TIN.)	
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	
NOTES AND SPECIAL INSTRUCTIONS: N/A			

DATA ELEMENT DEFINITION

ELEMENT NAME: PROVIDER TERMINATION DATE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-120	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.
DEFINITION	Date a provider is either suspended or terminated as a valid TRICARE provider (not to be used as the date a change was made to the file). If the provider was never qualified to provide services zero fill.
CODE/VALUE SPECIFICATIONS	Must be valid date, YYYYMMDD. Zero fill if not applicable, or if provider acceptance date is zero filled.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required if update is to suspend or terminate a provider.**

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DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROVIDER ZIP CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-060	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Nine (9) alphanumeric characters.
DEFINITION	Zip code for provider's health care business location where the care was provided. The first five digits are used along with other 'key' elements to uniquely identify multiple providers using the same Provider Taxpayer Number.
CODE/VALUE SPECIFICATIONS	Must be valid 5 or 9 digit zip code. If only 5 digits, left justify and blank fill. If a foreign country, must be 3 character foreign country code, left justify and blank fill. Refer to Chapter 2, Addendum A.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
[1] First 5 digits are required.

DATA ELEMENT DEFINITION

ELEMENT NAME:	**RECORD EFFECTIVE DATE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Provider	3-165	1	Yes

PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.
DEFINITION	Date to indicate the effective date of the data on this record.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**RECORD TYPE INDICATOR**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-001	1	Yes
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Code to indicate the type of record.		
CODE/VALUE SPECIFICATIONS	3	Provider	
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**RURAL/URBAN INDICATOR**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-125	1	Yes[1]
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Indicates for DRG amount calculation whether the institution is located in a rural or urban area.		
CODE/VALUE SPECIFICATIONS	L	Large Urban	
	R	Rural	
	U	Urban	
	b	Not applicable	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Report blank for all non-institutional providers and all DRG-exempt institutional facilities not reimbursed using a Rural/Urban Indicator.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**TRANSACTION CODE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-160	1	Yes[1]
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Code used to identify type of processing to be done on the record.		
CODE/VALUE SPECIFICATIONS	A	Add a record	
	M	Modify a record	
	I	Inactivate a record	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **A record must be on file to Modify or Inactivate. A record cannot be on file to do an Add.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**TYPE OF INSTITUTION CODE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Provider	3-095	1	Yes
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Code used to identify TYPE OF INSTITUTION as short or long term.		
CODE/VALUE SPECIFICATIONS	S	Short term	
	L	Long term	
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

CHAPTER 2
SECTION 2.11

DATA REQUIREMENTS - PRICING RECORD DATA

DATA ELEMENT DEFINITION

ELEMENT NAME:	CATEGORY OF CARE FOR CONVERSION FACTOR	

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Pricing	4-035	1	Yes[1]

PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.	
DEFINITION	Code identifying the type of conversion factor by care type.	
CODE/VALUE SPECIFICATIONS	A	Anesthesia Conversion Factor
	B	By report (no conversion factor, no area prevailing)
	M	Medical Conversion Factor
	P	Pathology Conversion Factor
	R	Radiology Conversion Factor
	S	Surgical Conversion Factor
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
[1] **Must be blank on prevailing records.**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**CLASS OF PROVIDER**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Pricing	4-015	1	Yes[1]
PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.		
DEFINITION	Code to identify those exceptions to requirements governing development of profiles on a non-specialty basis.		
CODE/VALUE SPECIFICATIONS	01	Medical, MD, DOs	
	02	PHDs, Psychologists	
	03	Social workers, pastoral counselors, marriage and family counselors, mental health counselors and psychiatric nurse practitioners	
	04	Others not included in '01', '02', '03' or '05'	
	05	Chiropractor	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Must be used when different prevailing fees or conversion amounts are developed for different classes of providers. If developed for only one class of provider, report only in appropriate class.**

DATA ELEMENT DEFINITION

ELEMENT NAME: CONVERSION AMOUNT

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Pricing	4-030	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Seven (7) signed numeric digits including 2 decimal places.
DEFINITION	Monetary amount derived from Relative Value Unit and Conversion Factor to be used when a prevailing fee has not been established.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	Medical Relative Value Unit (RVU) times appropriate conversion factor for the procedure code. Appropriate conversion factor is based on whether the procedure code is a Medical, Radiology, Surgical or Laboratory procedure code.

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **This field is only required when pricing is based on the conversion factor methodology, but is not applicable for anesthesia services. Code zeros for anesthesia conversion records, all area prevailing and by report records.**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME: MEDICARE ECONOMIC INDEX PRICE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Pricing	4-040	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Seven (7) signed numeric digits including 2 decimal places.
DEFINITION	Monetary amount derived from application of the Medicare Economic Index (MEI) to prevailing fee or conversion amount.
CODE/VALUE SPECIFICATIONS	N / A
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **This field is required for all procedures subject to MEI requirements. Code zeros if not applicable.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PREVAILING FEE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Pricing	4-025	1	Yes[1]

PRIMARY PICTURE (FORMAT)	Seven (7) signed numeric digits including 2 decimal places.
DEFINITION	Prevailing fee for the procedure code.
CODE/VALUE SPECIFICATIONS	Must be numeric.
ALGORITHM	N / A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N / A	N / A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Code zeros on conversion and by report pricing records.**

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PRICING EFFECTIVE DATE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Pricing	4-050	1	Yes
PRIMARY PICTURE (FORMAT)	Eight (8) alphanumeric characters, YYYYMMDD.		
DEFINITION	Effective date of the data on the Pricing record.		
CODE/VALUE SPECIFICATIONS	YYYY	4 digit calendar year	
	MM	2 digit calendar month	
	DD	2 digit calendar day	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	
NOTES AND SPECIAL INSTRUCTIONS: N/A			

DATA ELEMENT DEFINITION

ELEMENT NAME:	PRICING PROFILE		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Pricing	4-045	1	Yes[1]
PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.		
DEFINITION	Number identifying the pricing period used to determine the allowable charge.		
CODE/VALUE SPECIFICATIONS	15 = 15 Profile	01/01/1995 - 01/31/1995	
	95 = 95 Profile	02/01/1995 - 12/31/1995	
	16 = 16 Profile	01/01/1996 - 01/31/1996	
	96 = 96 Profile	02/01/1996 - 12/31/1996	
	17 = 17 Profile	01/01/1997 - 02/28/1997	
	97 = 97 Profile	03/01/1997 - 12/31/1997	
	18 = 18 Profile	01/01/1998 - 01/31/1998	
	98 = 98 Profile	02/01/1998 - 07/31/1998	
	28 = 28 Profile	08/01/1998 - 12/31/1998	
	19 = 19 Profile	01/01/1999 - 01/31/1999	
	99 = 99 Profile	02/01/1999 - 01/31/2000	
	00 = 00 Profile	02/01/2000 - 01/31/2001	
	01 = 01 Profile	02/01/2001 - 99/99/9999	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Required on all pricing records, including conversion.**

Last Changed on 09/18/2001

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PRICING STATE OR COUNTRY CODE**

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Pricing	4-005	1	Yes

PRIMARY PICTURE (FORMAT)	Three (3) alphanumeric characters.
DEFINITION	Code assigned to identify the state or foreign country for which the pricing data was established. State codes will be left justified and blank filled to the right.
CODE/VALUE SPECIFICATIONS	Reference Chapter 2, Addendum A and Addendum B.
ALGORITHM	N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME:	**PROCEDURE CODE**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Pricing	4-010	1	Yes
PRIMARY PICTURE (FORMAT)	Five (5) alphanumeric characters.		
DEFINITION	Code indicating the procedure to which the pricing data applies.		
CODE/VALUE SPECIFICATIONS	Physician's Current Procedure Terminology (CPT-4) or TMA approved codes (Chapter 2, Addendum E). HCPCS National Level II codes.		
ALGORITHM	N / A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N / A		N / A	
NOTES AND SPECIAL INSTRUCTIONS: **N/A**			

DATA ELEMENT DEFINITION

ELEMENT NAME:	**RECORD TYPE INDICATOR**		
RECORDS/LOCATOR NUMBERS			
RECORD NAME	**LOCATOR#**	**OCCURRENCES**	**REQUIRED**
Pricing	4-001	1	Yes
PRIMARY PICTURE (FORMAT)	One (1) alphanumeric character.		
DEFINITION	Code to indicate the type of record.		
CODE/VALUE SPECIFICATIONS	4	Pricing	
ALGORITHM	N/A		
SUBORDINATE AND/OR GROUP ELEMENTS			
SUBORDINATE		**GROUP**	
N/A		N/A	

NOTES AND SPECIAL INSTRUCTIONS:
N/A

DATA ELEMENT DEFINITION

ELEMENT NAME: TYPE OF PRICING SERVICE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Pricing	4-020	1	Yes

PRIMARY PICTURE (FORMAT)	Two (2) alphanumeric characters.	
DEFINITION	Code to indicate type of service to which pricing data applies.	
CODE/VALUE SPECIFICATIONS	01	Professional Component
	02	Technical Component
	03	Medical
	04	Surgery
	05	Professional and Technical Combined
	07[1]	Psychotherapy
	08[1]	Psychotherapy (inpatient only)
	09	Anesthesia
ALGORITHM	N/A	

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

[1] **Codes 07 and 08 are not valid for psychiatric code conversion pricing records; use code 03 (Medical).**

CHAPTER 2
SECTION 3.1

GENERAL EDIT REQUIREMENTS - OVERVIEW

1.0. TMA EDITING SYSTEM

TMA relies upon the data received from the contractor to account for the expenditure of government funds and to develop statistical information. This information is used for the analysis of the TRICARE program, for reporting to Congress, and the Executive Branch, and for developing trends and budget projections. TMA processes health care data received from the contractor through the TMA editing system, to ensure the accuracy and integrity of its database. There are two basic types of edits in the TMA editing system:

1.1. Validity Edits

If any data element fails a validity edit the record will be rejected and returned to the contractor for correction.

1.2. Relational Edits

If any data element fails a relational edit the record will be provisionally accepted and returned to the contractor for correction. These records must be resubmitted as an adjustment by the contractor and will be flagged on the TMA database as provisionally accepted until they have been corrected by the contractor.

1.3. Records with validity edit errors will be returned to the contractor with the same batch / voucher identifier and must be corrected and resubmitted using the same batch / voucher identifier.

1.4. Records with relational edit errors will be returned to the contractor with the same batch / voucher identifier and must be corrected via the adjustment process and resubmitted with a different batch / voucher identifier.

2.0. TMA ERROR MESSAGES

TMA edits generate error messages if the required conditions are not met. The two major parts of an error message are the error code and the error message text. The error codes are structured to identify the data element in error by using the Element Locator Number (ELN) as the first four digits.

2.1. Error Code Structure

The error codes have the following structure:

2.1.1. Four Characters

Element Locator Number (ELN) (followed by hyphen)

2.1.2. Two Digits

Number of the Error Code for a given element (01 if only one error code exists for a given element, there may be gaps in the sequence for an element)

2.1.3. One Character

R - for relational edits

2.1.4. Blank

For "individual" validity edits

2.1.4.1. Occurrence Number Error

Identifies the occurrence position of the data in error.

Note: The error code on the Edit Error Report may have two additional digits which identify the unique number of the utilization / revenue occurrence within the record.

3.0. RELATIONAL ERROR CODES

For "relational" error codes, the ELN part of the error code represents an arbitrarily established leading data element in a relational edit.

4.0. RELATIONAL ERROR MESSAGES

Chapter 2, Section 3 through Section 8 contain a list of error messages sequenced by ELN. The top right part of each page identifies the type of record or records to which the edit applies. There are two parts to each edit - the validity edits and the relational edits.

4.1. Relational Edits

The relational edits list all the data element names to which an element is related, listing the complete error code and defining the relationship. Where the relationship is part of a different ELN, the error code is shown for reference to be used in looking up the relationship. The information in Chapter 1, Section 3 through Section 8 contain the pseudo code used by TMA to write the editing program modules. Additional edits or changes may be made by TMA to ensure that the data submitted is in compliance with the TRICARE Policy Manual and the Operations Manual. Records retained by the TMA editing system, accompanied by error reports, are sent to the contractor for correction and resubmission.

4.2. Date Validity Edits

All dates must be valid gregorian or julian dates.